STATE OF IDAHO

MENTAL HEALTH PLAN FOR CHILDREN AND ADULTS

FY 2004

Idaho Department of Health and Welfare

EXECUTIVE SUMMARY

Idaho's public Community Mental Health Services are administered by the Department of Health and Welfare. Services are delivered through seven geographically defined regional programs. Regional community mental health centers provide adult mental health service. Regional Children and Family Services programs (which deliver other child welfare services) provide children's mental health services. State-level programs (Mental Health for adults and Children and Family Services for children) provide statewide coordination and technical assistance to regional service programs.

The Idaho Community Mental Health Block Grant Application is a one-year plan (FFY 2004) for both children's and adult mental health services. The statewide mental health system vision and program priorities which guide the Plan were developed by the Mental Health Planning Council and the children's and adult mental health programs. The Planning Council's Annual Report to the Governor (June 2003) is also an important source of direction for the FFY2004 Plan.

The children's program plan for FFY 2004 focuses on developing a comprehensive system of care among child-serving agencies and on family involvement. This focus is consistent with an approved court plan that moves the entire children's mental health service system toward family involvement and interagency collaboration.

A major emphasis of the adult plan is the development of program standards, competencies and outcome measures in order to maximize supports to maintain persons with severe and persistent mental illness in the community. Maintaining and integrating funding for community mental health services, and consumer and family empowerment are also priority areas of the adult plan, as well as an emphasis of the themes of (a) accountability, (b) better integration of treatment for substance abuse, and (c) the vision and hope of recovery.

Both plans address efforts to improve access to mental health services in a state with large rural/frontier areas and rapidly growing population centers, strategies to reach the state's Native American and Hispanic minority populations, and the development of information systems and outcomes measures for improved accountability and continuous quality improvement. Another important aspect of both plans is the effort to partner with and influence further development of private mental health resources in a managed care environment.

STATE OF IDAHO
MENTAL HEALTH SERVICES FOR CHILDREN AND ADULTS
FY 2004
TABLE OF CONTENTS

SECTION I

STATE PLAN CONTEXT

A. CURRENT MENTAL HEALTH SERVICE SYSTEM

1. ORGANIZATIONAL STRUCTURE

The Idaho Department of Health and Welfare is an umbrella human services agency reporting directly to the Governor, and including the Divisions of Health, Information and Technology Services, Enterprise Information Systems, Human Resources, Family and Community Services, Medicaid, Welfare, and Management Services (Appendix A). Departmental services are delivered statewide through seven Health and Welfare service regions (Appendix B). All Community Mental Health Centers, Adult and Child Development Centers, and Children and Family Services Centers in Idaho are state-operated programs and facilities. All such services are provided through this regional system with each region comprising a specific catchment area.

Substance abuse services are administered by the Department of Health and Welfare, but the Department contracts for gatekeeping, program management and for prevention and treatment service delivery. The Department (in partnership with Regional Substance Abuse Authorities, consisting of stakeholders and local community representatives) sets priorities and standards, monitors contracts and provides system leadership and technical assistance.

The Department operates two state psychiatric hospitals, State Hospital North (Orofino, Idaho) and State Hospital South (Blackfoot, Idaho). The Idaho State School and Hospital (located in Nampa, Idaho) serves persons with developmental disabilities.

The Division of Family and Community Services (Appendix C) is responsible for adult and children's mental health and substance abuse services, services for persons with developmental disabilities, child welfare and adoption services, the services of the two state psychiatric hospitals and Idaho State School and Hospital.

Although mental health services for children, youth and adults are administered by the same Division, planning and service provision for children's mental health programs and adult mental health programs are administered from separate programs. It is the Department's philosophy that all children's services, including children's mental health services, are best provided through an integrated family and children's services program. Thus, the Children's and Family Services Program is responsible for children's mental health planning and services while the Mental Health Program is responsible for adult mental health.

The Department's family-centered philosophy and resultant service organization are reflected at the regional level where children's mental health services are delivered through regional Children and Family Services offices together with child protective and adoption services. The structure of children's mental health services is such that there are few budget line items. Services are provided through a blending and pooling of child welfare and other funds to provide maximum flexibility from all funding sources.

Adult mental health services are provided through seven regional, state owned and operated community mental health centers (CMHC's). A close working relationship exists between the regional CMHC's and the two state psychiatric hospitals. The central office Mental Health and Substance Abuse program provides system coordination and leadership, technical assistance, training and consultation to support and expand an organized system of care that is consumer guided and community-based.

Beginning in July of 1996, each CMHC and Children and Family Services Program was designated as a *Regional Mental Health Authority* (RMHA) as part of the implementation of the Medicaid Rehabilitation Option by private providers. This option continues to afford private agencies the opportunity to provide psychiatric rehabilitation services through public/private partnerships with RMHA's. In these partnerships, private agencies provide direct psychiatric rehabilitation services while RMHA's perform managed care duties including service pre-authorization.

2. STATE DEMOGRAPHIC PROFILE

(a) Population Density:

Idaho is a predominantly rural state. The state population in 2000 was 1,293,953, and it is ranked 39th in the nation for population. It occupies a total land and water area of 83,574 square miles and is the thirteenth largest state in area. Idaho has a diverse geology and biology, containing large areas of alpine mountainous regions, vast desert plains, farmland valleys, and deep canyons and gorges. Many areas of the state have few roads. Some areas are vast wildernesses with *no* roads. Only five out of a total of 44 counties meet the criteria of a Metropolitan Statistical Area (MSA) as defined by the Federal Office of Management and Budget. The remaining 39 counties are classified as rural (at least 6 people per mile) or frontier (less than 6 people per square mile). Thirty-six percent of Idaho's population resides in these rural and frontier counties. Sixteen of Idaho's counties are considered frontier. These frontier areas comprise 59% of Idaho's total land area. Two thirds of Idaho's landmass consists of state and federal public lands.

The delivery of needed mental health services in such rural and frontier environments poses many challenges. Foremost among these are:

(1) Low population densities spread across immense geographic distances;

(2) Limited access to trained mental health and related professionals;

(3) Disproportionate levels of poverty in rural areas

(4) Local units of government (cities and counties) typically lack sufficient resources to meet community needs. The state system provides most social services using a combination of federal and state funds.

Low population densities in many service catchment areas make it impractical to dedicate large amounts of resources/finances on predetermined categorical programs that may only be indicated for one or two individuals. This is especially true for programs such as inpatient and day treatment which require large amounts of "up front" resources to establish and support the program. Instead of pre-dedicating resources to categorical programs, a rural service system must maintain resource flexibility and creativity while being as responsive as possible to individual, family and community needs.

(b) Population Growth

Idaho's population in 2000 was 1,293,953. This was an increase of 287,219 (28.5%) since 1990, the 5th highest in the nation. Three-fourths of the population growth has occurred in urban areas, notably Ada, Canyon and Kootenai counties. The population of Coeur d'Alene in Kootenai County grew 55.7% from 1990 to 2000. During the same time period the population of cities in Ada and Canyon Counties has increased as follows: Boise (47%), Meridian (264 %), Nampa (84 %) and Caldwell (40%).

(c) Economy

Like the rest of the nation, Idaho has suffered a lagging economy and lower than expected state revenues during SFY 2002 and 2003. While the traditional resource-based industries of agriculture, forest products and mining continue to contribute to the economy, high-tech, tourism, retail trade, and healthcare are among the growth sectors. Economic growth over the next few years is expected to occur at a slower rate than in the 1990's, but still higher than the nation as a whole.

(d) Racial /Ethnic Composition

According to Year 2000 census data, 91% of Idaho's population is white. The racial composition of the remaining 9% of Idaho's population is as follows:

AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN/ PACIFIC ISLANDER	LATINO/ HISPANIC
0.4%	1%	1%	7.6%

Idaho's largest ethnic minority, representing 7.6% of the state's total population, is of Hispanic/Latino heritage. Regions III and V (see Appendix D) contain the predominant concentrations of people with Hispanic/Latino heritage. Up to 15% of the total population of these two regions is of Hispanic/Latino heritage and culture. Inclusion of Idaho's Native Americans is a high priority of the State Planning Council on Mental Health. A map showing the location of the Native American tribes in the state is included as Appendix E.

(e) Per Capita Spending
According to a study of FY1997 data (the latest year available) by the National Association of State Mental Health Program Directors- Research Institute (NASMHPD-RI), Idaho ranked 49th lowest nationally in overall public mental health services expenditures, and 47th lowest nationally on a per capita basis.

(f) Suicide Rates
Like all of the other Western States, Idaho ranks high in suicide rates. The most recent data available (1998) from the American Association of Suicidology (AAS) show that on a per capita basis Idaho ranked 8th highest nationally for completed suicides. Suicide is the 2nd leading cause of death in the 15-34 age group (Idaho Vital Statistics, 2001)

3. PUBLIC AND STAKEHOLDER PARTICIPATION

(a) Regional Mental Health Advisory Boards (RMHAB'S)

Idaho has a long history of citizen and stakeholder participation in the mental health system at the regional level. RMHAB's have been in active existence since the early 1970's (Idaho Code 39-3130) and continue to play an important role. For example, each RMHAB contributes to and monitors the State Plan, and an RMHAB member from each region has a permanent seat on the State Planning Council.

(b) State Planning Council on Mental Health

A single Council oversees the development of both P.L. 102-321 Adult and Children's Plans. The Council has the required membership with less than 50 % of the members being state employees and/or service providers (Appendix Q). Representatives from the areas of housing, law enforcement, education and vocational rehabilitation are also members. Both adult and children's mental health planning issues are addressed by the Council.

The State Planning Council on Mental Health prides itself on being very active and participatory. Consumers, family members, and advocates far outnumber state employees and providers in attendance at meetings. Council members are well informed on the issues facing the public mental health system. Council members and the two Bureaus (Bureau of Mental Health and Substance Abuse and the Bureau of Children and Family Services) have a long history of fostering a good working relationship characterized by mutual respect.

In 1999 the Planning Council established a new subcommittee, the Performance Indicators and Outcomes Committee. This decision reflects the increased importance the Council is placing on having quantitative data, including outcome data, on which to base their decisions and recommendations.

From a children's mental health perspective, the Council strives for participation from families and to identify family members from each region of the state. These are families of children with an SED who have received or are currently receiving services. The services do not necessarily need to be received from the Department of Health and Welfare. These family

members are able to represent their local communities and are in a position to form a working relationship with their local Children and Family Services administration. Attendance by family members has increased with the help of the Idaho Federation of Families for Children's Mental Health. Currently, six of the seven family seats are filled and there is a stronger representation of family members at the regional level.

The Council maintains a standing Children's Mental Health subcommittee, which assures more in-depth review of children's issues including monitoring of the children's mental health system.

The State Planning Council on Mental Health meets three times a year, for 2 days each time. The Council's Executive Committee meets more frequently (if necessary) by conference call to address emergent business and plan upcoming meetings. The FACS Division Administrator and Deputy Division Administrator, or their designees, also attend Council meetings.

Beginning in FY98, the Council became increasingly active in oversight of the public mental health system and review and approval of P.L. 102-321 Adult and Children's Plans. A conscientious effort was made by the Council to assuage any concerns that the Council might be a "rubber stamping" entity. Council meeting dates were shifted to the beginning of August to allow for early review of the combined plan by all Council members and formal review and comment on the combined plan takes place only when all substantive edits are made and approved by the Council.

(c) National Alliance for the Mentally Ill- Idaho Chapter (NAMI-Idaho)

Since 1996, NAMI-Idaho has continued to make important contributions, and grow as an organization, and has in part been supported by a contract with DHW, managed by the Bureau of Mental Health & Substance Abuse. Under this contract, NAMI-Idaho provides information, support, technical assistance and coordination of self-help efforts to family members of adults with serious mental illness in Idaho. One important achievement has been the re-vitalization and increase in the number of local (regional) affiliates. In 2001, NAMI Idaho partnered with Idaho State University to provide education in the school system. The "Red Flags Idaho" program was implemented in August of 2001 with funding from the Idaho Department of Health and Welfare and continues into the current year with funding provided through the Governor's wife, Patricia Kempthorne. NAMI Idaho has also offered the "Family to Family" program for the past three years. This program educates family members of those with a mental illness on how to better assist their loved ones and how to take care of themselves as well. NAMI Idaho was awarded the "Outstanding Organization of the Year" Award from NAMI National during the NAMI 2002 national conference. The current Executive Director is Lee Woodland. More information about NAMI-Idaho is available at: http://www.namiidaho.org/.

(d) Office of Consumer Affairs & Technical Assistance

Idaho has had an Office of Consumer Affairs and Technical Assistance since February of 2000. It has resulted in significant progress in the level and quality of consumer participation, both at the state and regional levels. The current Director is C. Joseph Drayton.

(e) Idaho Federation of Families for Children's Mental Health

The Idaho Federation of Families for Children's Mental Health (Federation) is a chapter of the National Federation of Families. The Federation has played a significant role in the children's program over the last two years. The Federation is a member of the State Mental Health Planning Council, Idaho Council on Children's Mental Health and is a member of the Department's Children's Mental Health Subcommittee. All of these are policy and program development activities. In addition, the Federation has taken on the responsibility of identifying and recommending parent representatives for the State Planning Council on Mental Health, and participating on local councils when needed.

The Department has had a contract with the Federation to provide a statewide parent advocacy organization, parent participation and to develop a statewide network of family to family support. The Department is currently working on the finalization of a new contract with a family run organization. The current Federation Administrative Director is Marlyss Meyer. More information about the Idaho Federation for Children's Mental Health is available at: http://www.idffcmh.org.

(f) Idaho Council on Children's Mental Health

The Governor established through Executive Order the Idaho Council on Children's Mental Health (ICCMH), (Appendix F). Lieutenant Governor Jim Risch chairs this cabinet level council with members from the Governor's Office, the judiciary, the legislature, the Directors of the Departments of Health and Welfare and Juvenile Corrections, the State Department of Education, the State Planning Council on Mental Health, a parent representative, a county commissioner and a provider of children's mental health services. This Council is responsible for overseeing a court-approved plan for implementing the recommendations of the 1999 Needs Assessment.

4. CURRENT PRIORITIES FOR THE ADULT SERVICE SYSTEM

The State Planning Council on Mental Health has established the following priorities for adult mental health:

? **Increased funding (linked to data and outcomes)**

< Recommend submitting funding decision units to DHW Administration
<Gather data to demonstrate service need
<Get support from broad-based advocacy groups
<Recognize that outcome measures are the most persuasive data

? **Fund development of data gathering and analysis systems**

? **Equitable access to care regardless of age, funding, geography**
<Transition - child to adult
<Transition - hospital to home (continuity of care)

<Transition - incarceration to community
<Explore new technologies to improve access in rural areas

? **Quality**

<Develop professional competencies and standards
<Clearly define the role of state government in system oversight
<Urge the State to seek accreditation for State Hospital North

? **Continuum of care**

<Define and further develop an array of mental health services
<Keep resource development participant focus - vs. programmatic / institutional focus
<Promote and support early interventions

? **Education, Dignity, Stigma**

<Provide ongoing training for law enforcement officers around mental illness
<Continue to enlist NAMI-Idaho to assist with education efforts
< Seek alternatives to law enforcement transport of persons in psychiatric crisis

? **Community Supports - (Housing and Employment)**

<Continue to provide opportunities for clubhouse development in Idaho
<Recognize and utilize community support groups - Example: Dual Recovery Anonymous (DRA)
<Promote and provide opportunities for volunteerism
<Develop resources for employment /education / training/ rehabilitation/housing
<Increase transportation options, especially in rural areas

? **Consumer/ Family Member Involvement**

< Continue to support a State Office of Consumer Affairs
<Reinstate support for the Idaho Leadership Academy
<Recognize the efforts of the Mental Health Association of Idaho (MHAI) and statewide consumer groups,
<Support the National Alliance for the Mentally Ill, Idaho Chapter (NAMI)
<Continue to support statewide family coordination
<Recognize the efforts of the NAMI Family-to-Family Program
< Recognize the efforts of the Idaho Federation of Families for Children's Mental Health Program

5. CURRENT PRIORITIES FOR THE CHILDREN'S SERVICE SYSTEM

The State Planning Council on Mental Health has established the following priorities for children's mental health:

? **Continue work toward full implementation of the Jeff D court ordered Plan.**

The State Planning Council considers this the top priority for Idaho's children's mental health system.

? **Transition of children from their current program to:**

- **adult mental health services**
- **juvenile and adult corrections**
- **educational, school-based program**
- **to or from more restrictive levels of care**

Transition from children's mental health services to adult mental health services continues to be an issue. It has been determined that approximately 2% of those children labeled SED will have continuity of services as they age into the adult system. The Department must continue with its plan to develop transition services for those youth who (1) need ongoing mental health services yet do not have a DSM IV diagnosis and (2) drop out of school at age sixteen and older, are still in need of mental health services yet do not have the school to help them coordinate services.

? **Enhanced community-based efforts at all levels within the community. Expand and refine collaboration, and remove barriers to coordination.**

<statewide Interagency Council (ICCMH)
<Regional and Local CMH councils
<implementation of the recommendations addressed in the CMH Needs Assessment.

? **Increase services, increase continuous access to these services, and removal of barriers in rural areas of the state.**

? **Public education to promote awareness of mental health issues in general, access to services, available resources, knowledge of the Children's Mental Health Services Act, and recognition of a problem.**

? **Suicide prevention and education about causes suicide and at-risk populations.**

Idaho consistently ranks in the top five states for teen suicide. This alarming issue was identified as a major area of concern by the State Planning Council, participants in the Needs Assessment, school-based personnel, and the State Interagency Council. It is imperative that resources, methods, and curriculum be developed for and utilized by all child serving agencies, families and youth. A statewide suicide prevention plan is currently under construction and should be completed within the year.

? **Improve recruitment and retention of CMH professional.**

? **Continue agency/system change in philosophy and practice towards a system of care.**

? **Increased early intervention and prevention services.**

? **Enhanced data systems, service and outcome evaluation.**

? **Improved dialogue about mental health services for children and their families, recognizing the unique needs of each Idaho Tribe.**

? **Enhanced efforts to plan for, coordinate and provide services to children with a dual diagnosis of severe emotional disturbance and substance abuse or developmental disability.**

6. CURRENT ACCOMPLISHMENTS AND NEEDS

The most comprehensive and credible assessment of our system's current accomplishments and needs can be found in the State Planning Council on Mental Health's "Annual Report to the Governor, 2003." This report, required as part of Executive Order 98-06, which establishes the Council and defines its responsibilities, was approved by the Council at their April 2003 meeting and subsequently submitted to Governor Dirk Kempthorne in June, 2003. It is reproduced below in its entirety:

Idaho State Planning Council on Mental Health
Annual Report to the Governor
June 2003

The State Planning Council on Mental Health, pursuant to Executive Order #98-06, is pleased to submit to you our 2003 annual status report on state funded mental health services to Idaho adults and children and their families. We urge your continued leadership on behalf of adults with serious mental illness and children with serious emotional disturbance, especially because we do not see this leadership coming from the Legislature. In particular, we need adequate funding for effective, evidence based treatment for both children and adults.

We are pleased to acknowledge several accomplishments that are moving our mental health system in a positive direction:

- We appreciate your continued support for the Idaho Council on Children's Mental Health (ICCHM) which is chaired by Lt. Governor Risch. Through the efforts of the ICCMH, there are 31 local councils and 7 regional councils established throughout the state. All of these councils are working on interagency coordination, family involvement and improving services to children and families at the local and state levels.

- We applaud the Department of Health and Welfare's application for and receipt of a Federal Cooperative Agreement aimed at developing and improving the current efforts

under way in children's mental health. The ICCMH is functioning as the governance body for the Federal Cooperative Agreement for the development of systems of care for Idaho's children and families. The project will increase the amount of information and data regarding services provided and support training to optimize the function of Regional and Local Councils.

- We commend Mrs. Kempthorne for her ongoing support of the Red Flags Program, the Suicide Prevention Conference, the Real Choices anti-stigma campaign and the Respite Care Project. These programs have resulted in greater public awareness of mental health issues.

- We acknowledge the adjustment in the gravely disabled definitions within the Idaho Civil Commitment Code which paves the way for more timely treatment for persons with serious mental illnesses.

In addition to these significant accomplishments, we wish to acknowledge, on a state level, the following activities:

- Training for law enforcement regarding mental health issues.
- Telehealth activities that increase access to mental health services.
- Efforts by the Suicide Prevention Action Network and statewide community members to develop a statewide suicide prevention plan.
- The development of a mental health court in District VII.
- Reinstatement of some adult dental services in Medicaid.
- Availability of drug settlement funds to purchase high cost psychotropic medications for uninsured consumers.

CHALLENGES

Unfortunately, some of the notable accomplishments listed above pale in comparison to the many challenges Idaho continues to face. We are listing the most important challenges below in the hope that you will give the support of your office in addressing them:

- The population of the state continues to grow, yet resources for publicly funded mental health services have been reduced. Funding affects the amount of community based services and impacts at the personal level the individuals in need of recovery and treatment. We endorse full funding and staffing of Assertive Community Teams throughout the state as a method of reducing hospitalization and maintaining individuals in their communities.

- Quality assurance of publicly funded mental health services that includes knowledgeable, educated, involved consumers, provider participation, focus of services on recovery and outcomes and timely implementation of sanctions when needed is not yet in place in Idaho. We strongly recommend the direct involvement of family members and consumers in the development and monitoring of performance standards and service outcomes. More specifically, we recommend that an automated solution be developed to provide

consumers with timely information about the services and benefits they receive. This would assist consumers to become more active in monitoring the services they receive as well understanding the cost of those services.

- More opportunities are needed for consumer and family member input and participation in the development of coordinated, effective mental health services. We urge the Department to identify and provide increased opportunities for consumers and family members to serve on policy and program development workgroups.

- After nearly 100 years of existence, State Hospital North is still not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). We strongly advise the Department to pursue JCAHO accreditation of State Hospital North as a demonstration of the state's commitment to quality mental health care.
- Currently, a large disparity exists in benefits provided by insurers for mental health services when compared to other health related services. We recommend the adoption of policies that would assure parity for consumers and families accessing needed mental health services through private insurers.

- Idaho would benefit from the expansion of mental health courts that are supported by strong community based treatment and services. We support mental health courts as a humane method of treating individuals within their communities and reducing recidivism.

- We continue to be concerned with the state's position of opposing the Jeff D lawsuit. Although additional funds and staff have been added in the last several years, there has also been a reduction in staff this past year. Despite twenty-three years of litigation, Idaho has still not fully implemented needed children's mental health services. We strongly endorse full implementation of the court plan.

- We consider the suspension of the Medicaid peer support waiver, the closing of the LAMP Program, failure to fund the Medicaid Buy-In Program and lack of funding for peer-to-peer education to be lost opportunities to improve services for individuals and families affected by mental illness in Idaho.

- The federal Performance Partnership Block grant for mental health services requires that Idaho establish a comprehensive, community based service for persons with serious mental illness. This includes access to healthcare, including dental services. We recommend full reinstatement of Medicaid adult dental services.

- Data collection continues to be an important issue. Although progress has been made, we urge the Department of Health and Welfare to continue to dedicate resources to achieve the timeline for statewide outcomes data reporting for the Mental Health Performance Partnership Block Grant.

We thank you for this opportunity to provide you with our perspective on the mental health system in Idaho. As always, we extend an invitation to you or one of your staff members to join

us at our meetings. Our next meeting is scheduled for August 6-7, 2003, Boise Holiday Inn Airport.

Respectfully submitted,

STATE PLANNING COUNCIL ON MENTAL HEALTH

Rick Huber
Chair

dp

B. FUTURE VISION FOR THE MENTAL HEALTH SERVICE SYSTEM

The Idaho State Planning Council on Mental Health has established the following vision for our state's mental health system:

Idaho's public mental health system vision for service planning, development, and delivery is to promote a comprehensive, integrated, consumer and family-guided system of care. The system of care will (1) emphasize early intervention, (2) promote a normalized life, (3) cultivate natural supports, (4) encourage self-reliance, (5) enhance functional ability, and (6) recognize and support the diversity of individuals and families through:

- **IMPROVED ACCESS TO SERVICES**

Assuring consistency of services across regional boundaries

Facilitating access to services nearest a person's residence

Maintaining and expanding a continuum of care from most to least restrictive and across all ages (including 18-21 and 65 or older) and socioeconomic levels regardless of funding/resources.

Providing mental health services that focus on outreach, early detection and early intervention

Defining the roles of institutions, such as state hospitals, in a community-based system

Improving access to and availability of community-based crisis services

Addressing unique needs of rural communities for service delivery

Streamlining access to public mental health services

Increasing outreach to Hispanic and Native American communities

PUBLIC EDUCATION AND TRAINING

Increasing awareness and understanding of mental illness to decrease stigma and incidence of suicide

Educating the general public and other mental health service providers about public mental health services, including priority populations, core services, and resource allocation.

Fostering activities that promote acceptance and inclusion of persons with mental illness

QUALITY ASSURANCE AND INCREASED ACCOUNTABILITY

Recruiting, retaining, and valuing quality service providers. Good Employees = Good Services

Providing services that are culturally sensitive and relevant

Sponsoring ongoing training of public and private mental health service providers

Assuring clinical competence of public and private providers of mental health services

Recognizing and educating mental health service providers about the significance and interplay of dual diagnoses (mental illness/substance abuse and/or developmental disability)

Strengthening and expanding state oversight of mental health service provision

Establishing and adopting uniform standards of care for mental health treatment

Increasing consumer and family member involvement in service planning, programming, evaluation, and outcomes monitoring

PUBLIC AND PRIVATE COLLABORATION

Increasing collaboration between public and private mental health service providers and communities to reduce gaps in services

Improving protocols for client transition between public and private services

Encouraging integration of services and pooling of funds for more efficient use of resources

Jointly developing and enhancing community supports to address functional limitations

Facilitating information sharing between both internal and external stakeholders to coordinate and expedite service integration

- **INCREASED RESOURCES**

Pursuing increased public mental health system funding. (Current funding is insufficient for even basic core services.)

Exploring managed care initiatives, such as single stream funding and gatekeeping to extend limited resources

Augmenting the mental health provider network, including recruitment of mental health professionals in rural and frontier areas.

C. NEW DEVELOPMENTS AND ISSUES

1. State Economy and Budget Reductions.

Idaho, like much of the nation, suffered a lagging state economy and lower than expected state revenues during SFY 2002 and 2003. As a result, all state agencies were subject to a series of budget holdbacks totaling a cumulative 6% over the two years. The SFY 2004 budget did not include any increases for Division of Family and Community Services programs. These budget reductions are permanent, and cuts that have been made are not expected to be replaced in the future. Indeed, further cuts may be necessary.

2. Care Management for Adults with Developmental Disabilities

Health and Welfare is implementing a process called "care management" for adults with developmental disabilities. It is intended to provide Medicaid clients more choices in their care, provide them with quality services, and through this process, better control the state's growing Medicaid costs. Care management will allow for the delivery of better, more efficient, and cost-effective services to customers right in their communities. The plan consists of an independent assessment provider to identify needs and authorize services, a quality improvement plan to evaluate and improve the service delivery process and implementation of care management techniques to review how well services are actually delivered to our clients.

The Department conducted a pilot managed care program in Region 2 in SFY 2002, and is now moving ahead with implementation of a statewide program for adults with developmental disabilities. Implementation will require combining some Adult DD ACCESS Unit staff with Regional Medicaid Services staff, contracting with an independent assessment provider (IAP) and prior authorizing all adult DD services. The new business process is scheduled to begin in October 2003.

3. Any Door Initiative

The Any Door Initiative evolved out of The Idaho Department of Health and Welfare's Goal 5 to identify and recommend solutions for opportunities to align structures, people and technology while improving communication and customer service in support of the desired outcomes of all other goals. The vision of the initiative is that "Any Door" leads to healthy people, stable families, and safe children. The Mission is to improve client outcomes through the design and implementation of an integrated service delivery system. System design is scheduled to be completed by the fall of 2003with a pilot project ready for testing by January 2004. The initiatives goals are to:

- Create a service delivery system that ensures accountability, consistency and efficiency.
- Create a service delivery system that provides comprehensive services to help client reach their goals and transition to natural supports.
- Create a client-driven and outcome-based service system.
- Create a common enrollment process to provide easier access for clients.
- Create a single integrated case plan for families that contains an specialized service or treatment plans developed with the family.
- Integrate population-based services into the new service delivery system.

4. State Mental Health Data Infrastructure Grant

In June 2001 the state submitted an application to SAMHSA and was awarded a three-year State Mental Health Data Infrastructure Grant (Mental Health Statistics Improvement Program). This grant would enable the state to build the infrastructure needed to report all of the required data elements soon to be required for the Federal Community Mental Health Block Grant Plan. In addition, it will provide the state with the information it needs to better manage its services, as well as to be more accountable to the legislature and to its other stakeholders.

A Steering Committee and Operations Team monitor and coordinate the Data Infrastructure Grant (DIG) project. DIG became part of a larger project to integrate Developmental Disabilities and Mental Health (DD/MH) data collection into the existing Family Oriented Community User System (FOCUS) used by Children and Family Services. This larger DD/MH Integration project has been delayed by the issuance of an RFP for system development. In order to assure collection of MHSIP data by October, 2003, the Department pursued a contingency plan which has modified a currently-existing regional mental health data system. The system is nearing completion and will begin gathering required data as of the October deadline. A process will be developed to convert and download the data gathered and entered into the new DD/MH Integration system when that system was implemented.

5. Children's Mental Health System of Care

In December of 1998, a contract was developed between the Department of Health and Welfare and the Human Service Collaborative to conduct a needs assessment of Idaho's children with serious emotional disturbance and their families. On June 29, 1999 the completed assessment was presented to the Department of Health and Welfare, the Idaho Federation of Families for Children's Mental Health, the State Department of Education, the Department of Juvenile Corrections, the Governor's office, and various service providers. Added to the Needs Assessment was a cover letter signed by each of the Directors of the above named agencies. This letter states the commitment of each of these agencies to build a collaborative entity that will fulfill the recommendations of the Needs Assessment on behalf of Idaho families and their children with an emotional, behavioral, or mental disorder.

A plan for implementing the 50 recommendations of the 1999 Needs Assessment was negotiated between the State and Plaintiff attorneys in the Jeff D. lawsuit. The plan was filed with the court on February 9, 2001. The Federal Court approved the plan on June 4, 2001. This plan has major implications for the mental health delivery system for children. It sets forth a framework for community collaboration and has implications for service delivery for the Department of Health and Welfare, Department of Juvenile Corrections and Department of Education. The plan has specific action items with associated implementation dates.

As part of the court approved plan, the Governor established through Executive Order, the Idaho Council on Children's Mental Health (ICCMH), (Appendix F). Lieutenant Governor Jim Risch chairs this cabinet level council. Some of the responsibilities of the ICCMH are to oversee the implementation of the plan and inter agency coordination.

Regional and Local Councils are being developed in the seven regions within the state. Councils will be comprised of child serving agencies, providers and parents. These councils will assist in the development and delivery of coordinated, community-based services. The Regional Councils will report to the ICCMH on services, outcomes and service gaps.

The ICCMH is guiding the Department's implementation of the court-approved plan. The council provides a structured method for implementation and completion of the action items in the plan. The ultimate outcome of the plan will be the development of a coordinated community based system of care for publicly funded children's mental health services. The plan has specific action items with associated timelines for completion. The majority of the action items have been implemented as of the writing of this plan. These action items are consistent with the Block Grant Criterion and will form the basis of the objectives for the next year.

The Governor requested additional funding and personnel for children's mental health in two of the last three years. In 2001 the Legislature approved the governor's request and added another 15 staff and nearly $3.2 million in the Children and Family Services budget for children's mental health services and in the 2002 session the legislature approved funds for 10 new children's mental health positions and additional children's mental health services.

Medicaid also received an additional $2.5 million in combined state and federal funding for expected increases in Medicaid funded mental health services for children during the 2001 session. However, because of Idaho's fiscal difficulties, children's mental health shared in the need to reduce spending and reduce CMH staff by 14.5 FTE.

6. Interagency Work Group on Mental Health & Substance Abuse

A work group consisting of representatives of the Idaho Department of Health and Welfare, the Idaho Association of Counties and the Idaho Hospital Association are examining our current public system of care for both mental health and substance abuse. This group is interested in proposing changes to financing and service delivery in Idaho relating to both mental health and substance abuse services. The State Planning Council on Mental Health is represented on this work group by Arnold Kadrmas, M.D. It is anticipated that specific recommendations will be forthcoming from this work group during FY04.

7. Drug Courts

The Idaho Drug Court Act became effective July 1, 2001 and expanded drug courts to each of Idaho's seven judicial districts. Implementation of Drug Courts requires intensive teamwork at both the state and county level, including close collaboration of state agencies, particularly the Department of Health and Welfare, Departments of Correction and Juvenile Corrections, and the Idaho State Police.

Drug court teams work together to manage the drug court and plan each participants treatment, as well as, guide the sanctions and incentives for compliance with rigorous drug court requirements. Teams consist of prosecutors, defense attorneys, drug court coordinators, probation officers and treatment providers. Drug court treatment is provided by state certified providers, with most of the providers being a part of the statewide treatment network administered by the Department of Health and Welfare.

SECTION II

STATE MENTAL HEALTH PLANS

FISCAL PLANNING ASSUMPTIONS

For planning purposes, the State of Idaho is assuming a Federal Community Mental Health Block Grant (CMHBG) allocation of $1,801,576 in FY 2004. A summary of Federal CMHBG funding for the period 1999 – 2004 is detailed below.

Community Mental Health Program
History of Mental Health Block Grant

	Actual 1999	**Actual 2000***	**Actual 2001**	**Actual 2002**	**Actual 2003**	*Projected 2004*
Adult	830,684	902,534	879,648	923,947	923,947	923,947
Children's	186,636	99,384	107,086	112,298	112,298	112,298
Admin.	53,543	68,943	84,127	86,733	86,733	86,733
00 New Award $ (Adult Special Project)		154,000	154,000	154,000	154,000	154,000
00 New Award $ (Children's Special Project)		154,000	154,000	154,000	154,000	154,000
01 New Award $ (Adult Special Project)			253,677	253,677	253,677	253,677
01 New Award $ (Children's Special Project)			50,000	50,000	50,000	50,000
02 New Award $ (Adult Special Project)				45,638	45,638	45,638
02 New Award $ (Children's Special Project)				5,369	5,369	5,369
02 New Award $ (Admin.)				2,684	2,684	2,684
03 New Award $ (Adult)					12,568	12,568
03 New Award $ (Admin.)					662	662
Total Award	1,070,863	1,378,861	1,682,538	1,788,346	1,801,576	1,801,576

* Includes indirect support, regional support, and FACS Div.

CHILDREN'S PLAN FY2004

NARRATIVE, GOALS, OBJECTIVES, AND INDICATORS

CRITERION 1

COMPREHENSIVE COMMUNITY BASED MENTAL HEALTH SERVICE SYSTEM: Establishment and implementation of a community-based system of care for adults with serious mental illness (SMI) and children with a serious emotional disorder (SED), describing all available services including health (medical and dental), mental health, rehabilitation, case management, employment, housing, educational, other support services, and activities to reduce the rate of hospitalization of individuals with SMI or SED (previously criteria 1, 3, 4, 6 and 7).

A. NARRATIVE

1. ORGANIZATIONAL STRUCTURE OF THE COMPREHENSIVE SYSTEM OF CARE

Idaho Code section 16-2404(1) states that "The department of health and welfare shall be the lead agency in establishing and coordinating community supports, services and treatment for children with serious emotional disturbance and their families, utilizing public and private resources available in the child's community. Such resources shall be utilized to provide services consistent with the least restrictive alternative principle, to assist the child's family to care for the child in his home and community whenever possible. The state department of education shall be the lead agency for educational services."

Section 16-2404(2) states that "The department of health and welfare, the state department of education, the department of juvenile corrections, counties, and local school districts shall collaborate and cooperate in planning and developing comprehensive mental health services and individual treatment and service plans for children with serious emotional disturbance making the best use of public and private resources to provide or obtain needed services and treatment."

The Department of Health and Welfare is organized so that the children's mental health service responsibility resides within the same program (Children and Family Services) as child protective services, adoptions, foster care, Independent Living, Indian Child Welfare, and other child welfare related services. The adult programs, mental health and substance abuse, reside in the Mental Health and Substance Abuse program. Both programs are within the Division of Family and Community Services. State Hospital South has an adolescent unit for in-patient care and also falls under the same Division. Medicaid is a separate Division within the Department of Health and Welfare.

The Department, through the Division of Family and Community Services' Children and Family Services program, provides children's mental health services through seven regional service centers. Appendix B shows the seven regions and service office locations throughout the state. A variety of Children and Family Services (CFS) employees staff these regional field offices. Appendix H shows the distribution of CFS mental health clinicians available to children and their families. This network of field offices extends into all counties providing at least minimum access to departmental services across the state.

The State of Idaho is developing, implementing, promoting and evaluating an integrated system of care that is community-based and family focused for children with SED. Improving care requires Building on Each Other's Strengths. Idaho is combining family members, communities, and public agencies into lasting partnerships for care. Building on Each Other's Strengths is just beginning. Governor Kempthorne established the Idaho Council on Children's Mental Health (ICCMH) in 2001. The ICCMH is charged with the transformation of separate child serving agencies into a collaborative system of care. Under charter from the ICCMH, local community based councils join with civic leaders in each of the State's seven regions as regional councils. The regional councils provide resources, administrative oversight, and a communications link between the ICCMH and local community- based councils. The local councils provide comprehensive assessment, individualized service planning, and review for children with SED at high risk of out-of home placement.

- MENTAL HEALTH SERVICES

The system of care for children and youth with serious emotional disturbance encompasses those services provided through the Department of Health and Welfare and services provided by other public agencies, non-profit agencies and the private service sector. Appendix I illustrates the variety and scope of mental health related treatment facilities/programs throughout the state, including private sector treatment resources.

Private providers of mental health services exist throughout the state. Private provider services range from outpatient clinic services and psychosocial rehabilitation services to residential and inpatient care. Services may be paid through Medicaid, private insurance, self-pay, and contracts. Comprehensive services exist within the state, but not in all areas of the state or in sufficient quantity.

The Department has developed service definitions and measures for the following services within the comprehensive system of care (Appendix G):

- Assessment
- Case management
- Respite Care
- Family Support
- Therapeutic foster care
- Crisis response
- School Mental Health Services
- Outpatient treatment

- Residential Treatment
- Inpatient Hospitalization

These definitions will provide for consistency of services throughout the state, measure services provided, identify gaps in services, and clearly describe the comprehensive array of services. Additionally, the collaborative children's mental health system, lead by the ICCMH, produces a community report card on children's mental health that reports on the measures identified in Appendix G. The community report card may also include systems outcome and performance indicators.

The Department has recently developed CMH Core Service Standards for the 10 core services that give direction to each of the 7 Department regions. These standards provide direction in the development of the core services in each of the regions. The state is moving towards statewide consistency in the application of these services in order to best meet the needs of children with SED and their families.

The State of Idaho, through the Department of Health and Welfare, Division of Family and Community Services, operates one psychiatric inpatient unit for adolescents, State Hospital South Adolescent Unit (SHSAU). This unit has the capacity for 16 adolescents (ages 12 - 17 years of age).

The role of the SHSAU within the state's system of care is to provide inpatient stabilization and treatments requiring intermediate lengths of stay that average 45 to 90 days. Brief, short-term emergency/acute inpatient care must occur at a local level, not at the State Hospital level. Longer term care and treatment following stabilization at the State Hospital is a function of treatment families, residential treatment and group care.

The State Hospital utilization rate for youth in FY2002 was 16/100,000 for children under age 18. The State Hospital South Adolescent Unit admitted 69 patients within the twelve-month period. For FY2003, the average length of stay at SHSAU was 71 days.

- SERVICES TO THE DUALLY DIAGNOSED

Children and youth with co-occurring serious emotional disturbance and substance abuse disorders can access services for both, if they qualify, concurrently. Services are delivered by two different programs within the same division of the Department of Health and Welfare, the Division of Family and Community Services. Most services for both mental health and substance abuse are delivered by private providers; however, these services are expected to be delivered through a collaborative service model. The first step in the intake process for Children's Mental Health is to provide a comprehensive assessment to each child applying for services and substance abuse is assessed as an area for inclusion in recommendations for additional services.

- REHABILITATION SERVICES

In 1997, Idaho implemented the Rehabilitation Option as part of its Medicaid Plan. The intent of Idaho's Rehabilitation Option is to provide community-based services to children with serious emotional disturbance and to adults with serious and persistent mental illness. The SED definition used to determine Rehabilitation Option service eligibility is consistent with the federal definition pursuant to section 1913 (c) of the Public Health Service Act as amended by Public Law 102-321.

One key feature of Idaho's Rehabilitation Option is the recognition that Medicaid Rehabilitation Option funding is a public resource and should be expended on that population for which the public has service responsibility, the child with a serious emotional disturbance. The Rehabilitation Option is a vehicle through which public Medicaid resources can flow to the private sector enabling them to assist in serving the target population. The Regional Mental Health Authorities (RMHA), through their service provider system, accomplishes this. Each RMHA continues to build provider networks by forming public-private partnerships with providers who want to access Medicaid funds under the Rehabilitation Option. Interested providers negotiate and sign provider agreements with their RMHA. It is important to note that not all children are Medicaid eligible and therefore, the Department provides these same services through other funding sources to ensure equal access.

- EMPLOYMENT SERVICES

Employment services and transition services are a major responsibility of the State Department of Education (SDE). SDE was recently awarded a federal grant to improve secondary transition services by increasing the ability to gather data regarding performance indicators of post secondary school students. Additionally, the Department of Health and Welfare has in place a requirement of transition planning for any child receiving services by their 16th birthday. This includes both transition to adult mental health services and transition to adulthood and employment.

Youth in transition additionally have access to vocational rehabilitation services through Idaho Vocational Rehabilitation (IVR). This is accessed through their school or through direct referrals. IVR has its own eligibility criteria for services. Children that have been in placement for 90 consecutive days through a voluntary placement agreement also have access to Independent Living funds.

- HOUSING SERVICES

Idaho Code identifies services to children and youth as only being delivered to children whose parents have provided informed consent to the services. Typically the parents of the child have the responsibility to provide housing to children receiving community based services. However, every child whose parents have provided informed consent and apply for CMH service, receives a comprehensive assessment. The child's clinical case manager has a responsibility to assist the family in finding appropriate housing to care for their family needs.

Idaho Housing is a statewide agency that provides subsidized housing for low income families. Idaho also maintains a statewide toll-free phone number, called the Idaho Housing Information and Referral Center, to assist families in addressing their housing needs. The only way that an Idaho youth can be emancipated is through marriage and with their parent's consent, therefore there has been little need to assist with the housing needs to children served with the exception of transition. Please refer to Criterion 4 for additional information on services for homeless children and families.

- MEDICAL AND DENTAL SERVICES

Medical benefits to Children with SED may be provided through Medicaid, Children's Health Insurance Program (CHIP), private insurance, the county system and/or other private systems. Eligible children and families have access to medical and preventative health services through Health Districts. Idaho's seven health districts are primary outlets for public health services. These districts work in close cooperation with the Department of Health and Welfare and numerous other state and local agencies. Each district has a Board of Health appointed by the county commissioners within that region. Each district responds to local needs to provide an array of services that may vary from district to district. Services range from community health nursing and home health nursing to environmental health, dental hygiene and nutrition programs. Many services are provided through contracts with the Department of Health and Welfare. Additionally, the Children's Health Insurance Plan (CHIP) has had steady increase in enrollment. Although there have been considerable measures taken to reduce Medicaid spending, children's dental services are still covered. However, Idaho has very few dental service providers that will accept Medicaid insurance. Especially impacted by this shortage are the rural communities.

Idaho Medicaid is working toward enrolling all individuals with Medicaid or CHIP in the Healthy Connections Program. The Healthy Connections Program is a managed care model that requires a physician's referral for non-emergent health services. This has the potential to increase the overall quality of health care for Idaho's children with public health insurance. Healthy Connections referrals require physician's to give regular check-ups to children and be involved and informed of their mental health services, which improves the coordination between medical and mental health services.

Quality health care is more difficult to ensure for children without public health insurance. However, as part of the Comprehensive Assessment that is completed by the Mental Health Authority on every child receiving services, the medical history and current status is evaluated and, if needs are apparent, they can be included in treatment planning.

- EDUCATIONAL SERVICES

The State Department of Education (SDE) provides federal and state funding to 115 independent local school districts. Services provided under the Individuals with Disabilities Education Act are provided by the local school districts based upon the child's need and identified through the Individual Education Plan. Services are provided according to state and federal IDEA requirements. Education faces some of the same barriers as other child serving systems in Idaho. One of the major factors is the rural nature of Idaho and access to services in local communities.

More children would be served in schools with the development of more local resources. The Bureau of Special Education of the State Department of Education utilizes an advisory board, called the Special Education Advisory Committee, to provide guidance to education professionals as they work towards meeting the requirements of the No Child Left Behind Act.

School mental health services to students with SED are delivered through a partnership between local school districts and the Department of Health and Welfare. These services range from school companion services to intensive day treatment services. The State Department of Education and the Department of Health and Welfare have collaborated to create Student Support Standards that can be used to ensure that children with emotional and behavioral disturbance have the necessary supports to allow them academic success.

- SUBSTANCE ABUSE SERVICES

The Department's Substance Abuse services are delivered by contractors located across the state and range from preventative services to outpatient and intensive inpatient services. The following are the guiding principles expected of each substance abuse treatment provider.

- Are based on consumer needs;
- Involve communities in program development and oversight;
- Have measurable outcomes;
- Provide easy access and facilitate smooth transitions from service to service and provider to provider;
- Provide for a full continuum of services;
- Are managed by leaders who create a culture of quality, effectiveness and efficiency;
- Are staffed by qualified people committed to providing quality services in the most cost-effective and efficient manner possible; and
- Have fair and objective systems to manage consumer complaints and concerns and assess responsibility for those problems and concerns.

The Department maintains one statewide contract for substance abuse services with Business Psychology Associates (BPA). BPA then subcontracts in each region for individual services providers. Outpatient and inpatient services are available to every region in the state, but not necessarily located in every region of the state. Youth 15 years and under are required to have parental consent for services, while 16 and older can access services without parental consent.

- CASE MANAGEMENT SERVICES

Stroul and Friedman (1986) refer to case management as the "back bone of the system of care" and as the cohesive element that holds the system of care together. Case management plays a key role in the coordination of services to children and families in the system of care. The children and families encountering the Department demonstrate a multiplicity of needs. These multiple needs, in turn, result in multiple service/agency involvement. Since no one type of service or program element is sufficient to meet all needs of the child and family, case management is essential and includes several functions:

- Mental Health Assessment
- Service Planning
- Service Implementation
- Service Coordination
- Monitoring and Evaluation
- Advocacy

Clinical case management is the process of facilitating, linking, monitoring, and advocating for children and their families to ensure that multiple services, designed to meet a family's and a child's need for care, are delivered in a coordinated and therapeutic manner. Clinical case management should be child centered and family focused to meet the goals of treatment outcomes, to be culturally sensitive, community-based, and provided in the least restrictive, most appropriate and most cost-effective setting with the needs of the child and family dictating the types of services provided. Clinical case managers are trained mental health professionals who have a clinical knowledge of human behavior theories and psychopathology, as well as a thorough knowledge of the philosophy of various therapeutic approaches. Clinical case managers are able to provide accurate assessments, create and coordinate service plans, and know when and how to intervene.

One of the essential features of effective case management is the manager's ability to access a broad array of services on behalf of the child and family. Equally important is the case manager's ability to help develop an individualized service plan with the child and family. Effective case managers must acknowledge parents as equal partners in the treatment program. This means parents having a voice in all decision making regarding their children. Ideally, the parents are co-case managers. An effective case management system makes flexible funds available and easily accessible to the case manager and family.

Idaho's Children and Family Services program currently relies very little on receipts to fund services. Staffing of services, especially case management, continues to be accomplished through a mix of general and block grant funds. One of the recommendations in the court-approved plan is to explore the feasibility of billing Medicaid for case management. Another is to develop standards for case management to be applied consistently across the state. Clinical case management is the primary service that is delivered directly by Department clinicians. Case management may be this service system's greatest strength. However, while case management is a strength of the system, the system cannot meet the case management needs of all children and youth experiencing serious emotional disturbances due to capacity issues.

Children and youth with serious emotional disturbance who are Medicaid-eligible and are receiving services from the private service sector can access case management (called service coordination) through Medicaid's Early Periodic Screening Diagnosis and Treatment Program (EPSDT). Service Coordination provided by private practice Service Coordinators is a Medicaid-reimbursable service.

- ACTIVITIES TO REDUCE HOSPITALIZATIONS

The ability of a system of care to reduce restrictive inpatient placements is dependent upon that system's ability to provide alternative intensive community-based services. One strategy that the Division employs to help expand community-based service and reduce inpatient placements is to continue channeling financial resources from traditional out-of-home contracts to community-based contract services. Current efforts by the Department, the ICCMH and local councils will be strengthening community-based services.

The Children's Mental Health Services Act provides guidelines for accessing community-based services. The Act, in the purpose and legislative intent language, emphasizes that the mental health system be community-based. The law requires that services occur when the child is in the home whenever possible. It limits out-of-home placement to circumstances in which safety may be jeopardized or there is risk of substantial mental or physical deterioration without treatment out of the home. The law also prescribes guidelines for least restrictive treatment principles and safeguards and review processes to determine the necessity for initial and continued out-of home care. The continued expectation is that this comprehensive Act, passed in 1997, will be fully implemented.

In 1998, the Department instituted Medicaid Reform for children by allowing Medicaid payments for services in all licensed inpatient psychiatric hospitals. Previously, only psychiatric units attached to general medical and surgical centers could receive Medicaid reimbursement. Services in "free standing" psychiatric facilities or Institutes for Mental Disease (IMD's) were not Medicaid-reimbursable. Often the lack of available local acute intensive services in the community has contributed to a commitment and placement in the state hospital facility -- a facility often located hundreds of miles from the youth's home. In some instances, it has been necessary to make a voluntary inpatient placement away from the child's home and community. In rare cases, placement has been made out of state in a Medicaid-reimbursable unit. By making, all inpatient psychiatric hospital services Medicaid reimbursable, more children and youth have access to shorter-term, acute inpatient services closer to their homes and families. This feature of the state's Medicaid plan fills a gap in several local systems of care by providing emergency stabilization and averting penetration into "deeper end" levels of care. Implementation of a prior authorization and concurrent review process ensures there is a need for all admissions and continued stays.

The Division is committed to reduction of out-of-home placements while taking into account issues of risk/safety. Children are placed outside the home only when necessary as indicated by risk factors and/or the inability of the community-based service system to provide adequate services to assure safety. The Division uses regional placement review teams including the child and their parent(s)/guardian(s) as a mechanism for quality assurance, placement gate keeping, and intensive screening. All out-of-home placements (except for traditional foster care services) are reviewed to ensure that (a) out-of-home services are needed and (b) reasonable efforts have been made to prevent such placement. Following placement, a review process is used which focuses on (1) progress towards goal attainment while tracking determined measurable outcomes, (2) further planning (3) continued need for placement services, and (4) planning toward return to home or other less restrictive care. It is expected that this review process, as well as all treatment and transition plans, be done in conjunction with the child and his/her

family members. Providers must demonstrate family involvement as part of their contract criteria.

- OTHER SUPPORT SERVICES FROM PUBLIC AND PRIVATE RESOURCES PROVIDED TO ASSIST INDIVIDUALS TO FUNCTION OUTSIDE OF INPATIENT INSTITUTIONS

It is clear from the analysis of the target population and the prevalence figures of SED in children and youth (as provided in Criterion #2) that a considerable number of children with major mental health problems are not served by the public agencies. The majority of children with a SED who do not qualify to receive mental health services through the public sector, either are not served or are served through the private sector and/or school special education system. In addition, as the 1999 Needs Assessment points out, many of Idaho's children with a SED are served through the Juvenile Corrections system. While often inappropriate, this may be the only resource families have available to meet their children's mental health needs. A much larger private mental health system does exist and is comprised of various providers (Appendix I). Whether the private mental health service system has the capacity to serve the number of children and youth having serious emotional disturbance effectively is difficult to determine. The true capacity of the private provider system is unknown and there is currently no data system(s) which can determine an unduplicated count of the number of SED population who receive services from providers in the private service sector. This should be less of an issue as Children and Family Services moves into the "managed care" role and develops more private provider contracts.

The ICCMH, as described above, is developing a system of Regional and Local Councils to be available to families that present with significant cross-system needs. The Local Councils have a responsibility to staff cases with families and help to identify traditional and non-traditional services to assist in keeping children in the own communities.

B. GOALS, OBJECTIVES, PERFORMANCE INDICATORS

GOAL #1: **ENSURE THAT ALL CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES HAVE ACCESS TO AN ARRAY OF SERVICES WHICH EMPHASIZE COMMUNITY-BASED APPROACHES THAT ARE IN THE LEAST RESTRICTIVE SETTING AND HONOR THE CORE VALUES OF FAMILY INVOLVEMENT WITH NORMALIZED AND INDIVIDUALIZED CARE.**

Objective 1.1 **All families will have the opportunity to provide input on he services their child receives from the Department through the use of a family satisfaction survey.**

Population:	**Children with SED and their parents**

Criterion:	**Comprehensive community based mental health services.**
Brief Name:	Family satisfaction
Indicators:	? Percent of reporting families who rate access to services positively. ? Percent of reporting families who rate appropriateness of services positively. ? Percent of reporting families who rate involvement in service decision making positively. ? Percent of reporting families who rate effectiveness of services positively.
Measure:	
Numerator	Number of families reporting positively for each indicator.
Denominator	Total number of families reporting.
Sources of Information:	Family satisfaction surveys received and database used to record responses.
Special Issues:	Families will be given the opportunity to fill out a family satisfaction survey every 120 days and upon completion of services. Only those surveys returned will be recorded in the database. Of the 2282 families receiving ongoing services, 639 or 28% have responded to the survey. The input will provide the baseline of service satisfaction for which quality improvement will be measured in the coming years.
Significance:	Parental input is essential to the development, design and improvement of a comprehensive system of care. This objective relates to the State Planning Council's CMH priority: *Continue work towards full implementation of the Jeff D court ordered plan.*

	FY 2002 Actual	**FY 2003 Projected**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Percent of reporting families who rate access to service positively. 2. Percent of reporting families who rate appropriateness of services positively. 3. Percent of reporting families who rate involvement in service decision making positively. 4. Percent of reporting families who rate effectiveness of services positively.	93.1 % 97.3 % 93.8 % 97.2 %			
Value:				
Numerator: Number of families reporting positively for each				

indicator. 1. ACCESS 2. APPROPRIATENESS 3. FAMILY INVOLVEMENT 4. EFFECTIVENESS **Denominator:** Total number of families reporting.	 __595____ __622____ __600____ __621____ __639____		 _____ _____ _____ _____ _____	

Objective 1.2 **Thirty (30) local councils will be operational under the primary direction of the ICCMH with the Department taking the lead in the development of the local councils.**

Population:	Children with SED
Criterion:	Comprehensive community based mental health services
Brief Name:	Local Councils
Indicators:	Number of local councils established
Measure:	Number of local council charters that meet the standards established by ICCMH and the geographic area covered.
Numerator	
Denominator	
Sources of Information:	Local council charters
Special Issues:	Local councils require participation of the local child serving agencies. There may be some difficulty in establishing local councils as many of the key agencies are separate governmental units and do not fall under the control of the ICCMH or the Department. Operational will be defined as meeting the following criteria: 1) Chartered by a Regional Council; 2) Have an established membership; 3) Regularly scheduled meeting times; 4) Have staffed at least one case.
Significance:	The establishment of local councils will facilitate the development, enhancement, monitoring, and coordination of community based services. Local councils are necessary for interagency coordination, cooperation and collaboration at the community level. This objective relates to the State Planning Council's CMH priority: *Continue work towards full implementation of the Jeff D court ordered plan.*

	FY 2002 Actual	**FY 2003 Project**	**FY 2004 Objective**	**% Attainment**

Performance Indicator: 1. Number of local councils established	7		30	
Value: Number of local council agreements that meet the standards established by ICCMH and the geographic area covered.	7		30	
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

Objective 1.3 **The Department will implement a system of evaluating outcomes for youth served by Children and Family Services. The outcomes will be measured using the Child and Adolescent Functional Assessment Scale (CAFAS).**

Population:	Children with SED
Criterion:	Comprehensive community based mental health services
Brief Name:	CAFAS outcome data
Indicators:	Percent of children with a positive change in the CAFAS score over time. The CAFAS score will serve as the basis for determining functional impairment for this indicator. A CAFAS will be recorded upon initiation of services, at 120 day intervals and upon completion of services.
Measure:	
Numerator	Number of children receiving services with an improved CAFAS score.
Denominator	Total number of children receiving an initial CAFAS and an additional CAFAS following services.
Sources of Information:	Database used to record CAFAS scores.
Special Issues:	CAFAS is a method to measure a child's overall functional impairment. While the overall score may improve, a child may still experience difficulties in specific functional areas. Families and children may drop out of services prior to 120 days making a second CAFAS score difficult to accomplish.
Significance:	Improved functioning demonstrates the effectiveness of service interventions and leads to successful community integration of children with SED. This objective relates to the State Planning Council's CMH priority: *Continue work towards full implementation of the Jeff D court ordered plan.*

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. Percent of children with a positive change in the CAFAS score over time. The CAFAS score will serve as the basis for determining functional impairment. A CAFAS will be recorded upon initiation of services, at 120-day intervals and upon completion of services.	24 %			
Value:				
Numerator: Number of children receiving services with an improved CAFAS score.	___406___	_____	_____	_____
Denominator: Total number of children receiving an initial CAFAS and an additional CAFAS following services.	___1725__	_____	_____	_____

Objective 1.4 **An array of community-based services for children with SED will be available through Children and Family Services. These services will include assessment, case management, therapeutic foster care, crisis response, school mental health, outpatient treatment, residential treatment, family support services and respite care.**

Population:	Children with SED and their families
Criterion:	Comprehensive community based services
Brief Name:	Community based service array
Indicators:	Numbers of children with SED who receive a specific community based service. The Department will establish a method for tracking and reporting utilization of an array of community based services.
Measure:	Number of children receiving the specific service within the year.
Numerator	
Denominator	
Sources of Information:	Medicaid and FOCUS, CFS information system
Special Issues:	The CFS information system is now at a point where numbers of services can now be tracked. This will be the first year of this kind of comprehensive automated system reporting. Tracking services over

	time will indicate service enhancement.
Significance:	An array of community based services is essential for a comprehensive system of care to serve children with SED and their families. This objective relates to the State Planning Council's CMH priority: *Continue work towards full implementation of the Jeff D court ordered plan.*

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: Number of children with SED who receive a specific community based service. The Department will establish a method for tracking and reporting utilization of an array of community based services.	See Below			
Value: Number of children receiving the specific service within the year. Assessment: Outpatient Services: School Mental Health: Respite Care: Therapeutic Foster Care: Case Management Services: Family Support Services: Crisis Response Services: Residential Treatment Services:	 1802 1714 1059 53 42 2282 149 295 120			
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

CRITERION 2

ESTIMATES OF PREVALENCE AND TREATED PREVALENCE OF MENTAL ILLNESS: The plan contains estimates of the incidence and prevalence in the state of SMI and SED and contains quantitative targets to be achieved in the implementation of the mental health system, including the numbers of individuals with SMI and SED to be served (previously Criteria 2 and 11)**.**

A. NARRATIVE

1. GENERAL DESCRIPTION OF THE SED POPULATION

For purposes of estimating the prevalence of serious emotional disturbance and the scope of this public health problem among children and youth, Idaho continues to use the federal definition pursuant to section 1912 (c) of the Public Health Service Act as amended by Public Law 102-321 which includes those children and youth:
"From birth up to age 18, who currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. A substance abuse disorder or developmental disorder, alone, does not constitute a serious emotional disorder although one or more of these two disorders may co-exist with a serious emotional disorder. "

2. IDAHO PREVALENCE ESTIMATES

Serious emotional disturbance must be considered in a broad context, including and distinguishing among various degrees of emotional disturbance based on the levels of impairment. It is also important to show the relationships between these groups and Idaho's target population. To determine the prevalence of serious emotional disturbance among children and adolescents and their needs, the State of Idaho continues to use nationally obtained prevalence estimates.

The pervasiveness and persistence of a disorder are helpful in determining prevalence of serious emotional disturbance. Pervasiveness is usually measured by the degree of impairment to a child/youth's adaptive functioning or life skills. Most definitions of serious emotional disturbance require that, because of the mental illness, there be substantial or significant degrees of impairment in the youth's functioning in multiple life domains. The Center for Mental Health Services (CMHS) includes, as one component of its SED definition, "impairment such that there is substantial interference with a child's role or functioning in various life domains and adaptive skills" (Federal Register, May 20, 1993). Persistence or duration as a characteristic of a "serious" disorder is highlighted by Idaho Code. Idaho's Children's Mental Health Services Act

includes, as one element of its SED definition, that the disorder "requires sustained treatment interventions" (Idaho Code, Title 16, Chapter 24, sections 2403).

The estimated number of children under 18 years with an SED in Idaho is 18,452.1 (see table below). This estimate is based on the 2000 census data and uses a conservative estimate of 5.0% of Idaho's children under the age of 18 years.

Projected Population of Children with Serious Emotional Disturbance
By DHW Region, FY2004

	Regions							
	I	**II**	**III**	**IV**	**V**	**VI**	**VII**	**TOTAL**
2000 Estimated 0 to 17 Population (2000 Census Data)	47,405	22,853	58,196	93,799	47,619	48,362	50,796	**369,030**
Estimated 0 to 17 Population with Serious Emotional Disturbance (5%)	2,370.7	1,142.7	2,909.8	4,690	2,381	2,418.1	2,539.8	**18,452.1**

The public mental health system's capacity and resources are limited. Some children with emotional disturbance will receive services from the private service sector. Others will receive services from the education system, the five Idaho Tribes, and from the juvenile corrections system. Most agree the public sector's legitimate role in mental health service delivery is limited to the most seriously mentally ill.

Because of the service system's limited capacity, the target population (18,452) must be differentiated from the state's service goal -- those children who actually will receive public services. The target population (18,452) is the "pool" of youth estimated to have a serious emotional disorder with extreme impairment from which those receiving services will originate. It is estimated that 40% will need publicly funded mental health services and therefore, Idaho's service goal is 40% of the target population or 7,381 children and youth. This number is Idaho's target planning goal that, in turn, will drive public service system capacity development. This service goal includes children and youth with serious emotional disturbance served by Medicaid and/or the Mental Health Authority.

For purposes of service prioritization, a serious disorder is operationalized in order of priority:

I. The child is an imminent danger (risk to safety) to self or others (suicide/homicide) due to a substantial disorder of thought, mood or perception. This additionally includes the child who evidences an inability to meet basic needs for safety or evidences gross

impairment in reality testing such as requiring 24 hour supervision and care and as indicated by DHW's assessment process.

II. Due to the presence of a serious emotional disorder, the child is at risk of out-of-home placement, is currently in out-of-home placement, or is returning from a psychiatric inpatient or residential placement due to experiencing substantial multiple living problems including school, home, interpersonal or community, which are attributable to a substantial disorder of thought, mood, or perception.

III. Due to the presence of a serious emotional disorder, the child evidences substantial impairment in functioning in family, school or community, as determined by standardized measures/criteria.

The Department has adopted the Child and Adolescent Functional Assessment Scale (CAFAS) as the method for determining substantial impairment. The operational definition of SED for the Department must include a DSM-IV diagnosis and a functional impairment as documented by the CAFAS. The complete definition is:

> "An Axis I or II diagnosis according to the DSM-IV clinical criteria is required. A substance abuse disorder, conduct disorder, or developmental disorder alone does not by itself constitute a serious emotional disturbance, although one or more of these disorders may co-exist with a serious emotional disturbance. Co-existing conditions require a joint planning process that crosses programs and settings. V-Codes are not considered an Axis I disorder for purposes of this definition. The Child Adolescent Functional Assessment Scale (CAFAS) will be used to determine the degree of functional impairment. The child/adolescent must have a full-scale score (using all 8 sub-scales) of 80 or above and "moderate" impairment in at least one of the following three scales: Self-Harmful Behavior; Moods/Emotions; Thinking."

This definition is more narrowly defined than the federal definition as it excludes stand alone conduct disorder. This definition is used to identify the targeted service population. The prevalence and general estimates use the federal definition. As services and resources expand, the Idaho service definition may be modified to be more inclusive. The Department will review the operational definition annually to determine the need for modification.

3. ACCESS TO SERVICES FOR SPECIAL POPULATIONS

Two populations requiring special note are the highly rural and ethnic minority populations. Historically, these groups either do not have easy access to services, or if there is access the services are not relevant to their needs, strengths and contexts. Access to services for rural populations will be addressed in Criterion 4.

The dually diagnosed is another special population that requires a higher level of coordination and cooperation. The Idaho State School and Hospital (ISSH) is a state run institution that has historically served individuals with developmental disabilities. With the increasing identification of co-existing disorders, developmental disorders and mental illness, ISSH has expanded their

capacity to include dually diagnosed. Additionally, Medicaid and Family and Community services working together have developed an intensive community-based service called Intensive Behavioral Interventions (IBI). IBI is designed to provide skill-based rehabilitative type services to children/youth that have a developmental disorder and for the dually diagnosed. See Criterion 1 for information on services to children with co-existing substance abuse and serious emotional disturbance.

4. ETHNIC AND MINORITY POPULATIONS

Idaho is predominately a Caucasian state. According to Year 2000 census data, 91% of Idaho's population is white. The racial composition of the remaining 9% of Idaho's population is as follows:

AFRICAN AMERICAN	NATIVE AMERICAN	ASIAN/ PACIFIC ISLANDER	LATINO/ HISPANIC
0.4%	1%	1%	7.6%

Idaho's largest ethnic minority, representing 7.6% of the state's total population, is of Hispanic heritage. Region III and V especially have large concentrations of people who are Hispanic. (Appendix D)

Given that only 9% of the population is non-Caucasian, the system tends to be ethnocentric. This results in a general lack of development of services that are relevant to any group other than the dominant culture.

Planning for mental health services must more fully address access to culturally relevant services for this minority population. The Children and Family Services program has an Indian Child Welfare Program Specialist. Seventy-five percent of this permanent FTE position is allocated to network and coordinate activities with the six Idaho tribes to enhance Indian Child Welfare services (Appendix E). The Children and Family Services program has ongoing networking activities with the six Idaho Indian tribes through the Idaho State and Indian Tribal Child Welfare Committee that meets quarterly. Additionally, the Department continues to allocate $200,000 in Social Service Block Grant funds to the six Idaho tribes for the enhancement of tribal child welfare services.

In 2002, Idaho was awarded a Community System of Care Cooperative Agreement from SAMHSA, which Idaho titled "Building on Each Others Strengths." The primary purpose of Idaho's use of this Cooperative Agreement is the building of an infrastructure for Idaho's ongoing effort to build a System of Care. A major objective of Building on Each Other's Strengths is the development of a culturally competent system of care. Idaho is currently working on a technical assistance plan that has established cultural competence as a priority. Idaho has recently amended the Governor's Executive Order to include a tribal representative and a member from the Hispanic community.

Region III contracts with the Idaho Commission on Hispanic Affairs to provide information and assistance to Hispanic families about accessing services provided through the Department of Health and Welfare and through community providers. This affords the opportunity to provide more culturally relevant services than the regional service office could offer through its own internal resources.

B. GOALS, OBJECTIVES, PERFORMANCE INDICATORS

GOAL #2: **ENSURE THE DEPARTMENT OF HEALTH AND WELFARE, THROUGH ITS REGIONAL CHILDREN AND FAMILY SERVICES PROGRAMS AND MEDICAID, PROVIDES MENTAL HEALTH SERVICES TO CHILDREN REPRESENTING THE TARGET POPULATION.**

Objective 2.1 **Increase by 5% the number of children served through Medicaid and Children and Family Services programs.**

Population:	Children with SED.
Criterion:	Prevalence and number served
Brief Name:	Target Population Served
Indicators:	Percentage of the total population of children with SED that receive publicly funded mental health services.
Measure:	
Numerator	Number of children receiving services utilizing public monies for the year.
Denominator	The number of youth estimated to have a serious emotional disorder using prevalence figures this past year.
Sources of Information:	Medicaid reports and FOCUS, the CFS information system.
Special Issues:	The Medicaid figure showing the total number of children/youth served is important in that it shows the number of youth receiving publicly funded services through the private service system providers. These youth are in addition to those who are served by the DHW regional service offices. The total of both groups closely approximates all children/youth served through public funds available through the Department of Health and Welfare and is, therefore, considered part of the public service system. One caveat is that the information system cannot ascertain which of those youth served through Medicaid funding in the private provider clinic setting have conditions serious enough to be considered a serious emotional disorder. Certainly, some do have a serious emotional disorder while others may not meet the severity criteria. We are also unable to determine the number of youth with a

	serious emotional disorder receiving services in the private sector not utilizing public resources.
Significance:	Service capacity should increase over time with the development of more community based services. Increased capacity allows for more children to be served. Measurement of capacity and services is essential to the development of an adequate system of care to meet the needs of youth with SED and their families. This objective relates to the State Planning Council's CMH priority: *Increase services, increase continuous access to these services, and removal of barriers in rural areas of the state.*

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Percentage of the total population of children with that receive publicly funded mental health services.	63.3 %		66.5 %	
Value:				
Numerator: Number of children receiving services utilizing public monies for the year.	_11,687__	_____	_12,271__	_____
Denominator: The number of youth estimated to have a serious emotional disorder using prevalence figures this past year.	_18,452__	_____	_18,452__	_____

Objective 2.2 **Maintain local agreements or contracts to facilitate special population access to services.**

Population:	Children with SED.
Criterion:	Prevalence and number served
Brief Name:	Special Populations Served
Indicators:	Number of agreements or contracts.
Measure:	Number of agreements or contracts.
Numerator	
Denominator	
Sources of Information:	Regional Program Managers or contract officers
Special Issues:	Culturally relevant access to and delivery of services is necessary to increase services to special populations. Having contractors or state staff able to provide this is challenging given Idaho's demographic

	makeup. Future reporting requirements will be able to measure the impact on numbers served. The measurement will then be modified to document the number served as compared to previous years to show the impact of this objective.
Significance:	Making the access and services culturally relevant can increase the number of special population children served. This objective relates to the State Planning Council's CMH priority: *Continue agency/system change in philosophy and practice towards a system of care.*

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. Number of agreements or contracts.	3		3	
Value: Number of agreements or contracts.	3		3	
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

CRITERION 3

INTEGRATED CHILDREN'S SERVICES PROVISION: The plan provides a comprehensive system of integrated community mental health services appropriate for the multiple needs of children. (previously Criterion 9)

A. NARRATIVE

1. INTEGRATED SYSTEM OF CARE MODEL

Idaho's system is a state-operated public mental health system administered through the Department of Health and Welfare with direct services provided through seven service regions. As stated in Criterion 1, the Department of Health and Welfare is the lead agency in the coordination of mental health services. To understand Idaho's system for children's mental health services, one must be familiar with the integrated children's service system model.

The Georgetown University CASSP Technical Assistance Center (Stroul and Friedman, NIMH 1986) has developed a system of care model that outlines the various dimensions comprising a

total system of care. That model is function-specific rather than agency-specific and includes the following dimensions:

1. Mental health services
2. Social services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Family Support services

Idaho's system of care model views these same dimensions, in addition to family organizations, juvenile corrections and substance abuse, as the important service components comprising a system of care. Idaho has organized its service delivery model according to the philosophy of integrated services. Children with serious emotional disturbance have multiple service needs. Their multiple needs cross traditional agency boundaries. Because of cross-agency involvement, coordination of services is a major issue for the family who has a child with a serious emotional disorder. Without such coordination, the potential for fragmentation of services is great. This occurs as gaps form between the boundaries of the separate programs. Families fall through these service gaps unless special bridges are formed to join the service functions. The integrated service model is an attempt to reduce the separation and resultant fragmentation between the services. Case management is the mechanism for coordinating and integrating the various services and service providers.

Since most service functions are provided by different child-serving agencies, both public and private, the Department seeks to develop interdepartmental agreements that provide for jointly operated and funded mental health services. The Department of Health and Welfare has developed, with the State Department of Education, the Department of Juvenile Corrections and the Department of Correction a Children's Mental Health Interagency Agreement. The purpose of this agreement is to foster collaboration in planning, developing and providing services to children whom are eligible for mental health services and to clarify financial responsibilities and develop methods to collaboratively use existing resources. The goal is to provide services that meet the child's need in the least restrictive setting without compromising the safety of the family or community.

In the current Children and Family Services program, within the Division of Family and Community Services, children's mental health is integrated with child protective services, adoption/foster care services, Indian Child Welfare, and other child welfare functions. Within these programs, unlike more traditional programs, there are few boundaries and little separation of programs. Integration of services for children involved in the child protection system and who present with serious emotional disturbance can more easily occur.

The Rehabilitation Option represents a first step in the establishment of a single, fixed point of responsibility for client care and treatment for all Medicaid clients receiving services under the Rehabilitation Option. This function resides in the Regional Mental Health Authority (RMHA). The RMHA's ensure an integrated and coordinated service system for children with serious emotional disturbance through their ability to form public-private partnerships with multiple Medicaid service providers. Additionally, the RMHA's have the role of 1) assessing and

determining treatment needs, 2) authorizing services, 3) coordinating and integrating services, 4) monitoring services, and 5) ensuring client outcomes across several domains.

As one attempt to integrate children's services, the Departments of Health and Welfare and Education created an interdepartmental agreement. This agreement provides for the development and implementation of collaborative and jointly operated community-based intensive school-based programs. All regions of the state now have jointly-sponsored, school-based programs for children with serious emotional disturbance. These programs blend a combination state Children's Mental Health funds, State Department of Education, and local school district funds targeted for special education services under the Individuals with Disabilities Education Act (IDEA). These programs range from traditional day treatment program models to classroom-based program models. The eligible population for these jointly-sponsored, intensive school-based programs includes children and youth identified as seriously emotionally disturbed according to the educational system's criteria and students identified by Children and Family Services criteria. It is recognized that the capacity of these programs falls short of meeting current needs.

The Idaho State Department of Education and the Department of Health and Welfare provide health, mental health and educational services under the requirements of IDEA. These services are delivered primarily by local school districts and through collaborations with other child/youth serving agencies.

The Department is also responsible for the Children's Health Insurance Program (CHIP) through the Division of Medicaid. Medicaid is responsible for the eligibility and funding for the CHIP program. Issues concerning mental health services are coordinated with the adult and children's mental health program through the Technical Support Team (TST). This team provides technical assistance, coordination and recommendations concerning mental health services funded by Medicaid.

The Department of Health and Welfare has begun a project that is charged with the development of an integrated service system, called the Any Door Initiative. The goal of the project is to create a point of entry for families and individuals which gives them access to the array of services offered by the Department. The Any Door model recognizes that a major criticism of the Department is the number of different programs that work independent of one another and the struggle for a family or individual to access services in a large bureaucracy. The Any Door project will provide families with one point of entry that will assess their needs and create a single over arching service plan for the family. The intent is that if a family's needs are met in a comprehensive way, they will more quickly get their needs met and no longer need intensive services. The Any Door Initiative has the entire array of services under its scope, including;

- Social Services
- Medicaid
- Health and Injury Prevention
- Self-Reliance/Financial Support (Welfare)
- Substance Abuse
- Adult Mental Health

- Developmental Disabilities
- Infant and Toddler Program
- Child Welfare
- Children's Mental Health

2. REGIONAL AND LOCAL COUNCIL DEVELOPMENT

The 1999 Needs Assessment of Idaho's Children's Mental Health System recommended the development of local children's mental health councils to bring the system of care to the local level. In order to achieve this, Idaho Governor Dirk Kempthorne created through executive order (see Appendix F for Executive Order and membership list) the Idaho Council on Children Mental Health (ICCMH). The ICCMH provides for interagency collaboration at the state level and interagency collaboration through the development of Regional and Local councils.

Regional children's metal health councils are administrative in function and mirror the ICCMH in membership on a regional and local basis. Regional councils are responsible for reporting to the ICCMH on common data elements, fiscal management of local councils, monitoring local councils, assessing and identifying gaps and system planning/development. Local children's mental health councils are currently under development. There will not be any restriction on the number of local councils that are developed, assuming they meet the requirements for membership. At the time of this report there are approximately 30 local councils under development. Local councils will serve children with serious emotional disturbance that impact multiple children serving systems. Local councils will serve many purposes, but primary duties include staffing and case planning for children and families as well as serving as the local locus of collaboration. Membership on the regional and local councils may include Health and Welfare, education, juvenile probation, Juvenile Corrections, parents, parent advocates, private providers, and other interested community members. The ICCMH has developed the standards for regional and local councils. The ICCMH has the responsibility to charter the regional councils (which has been completed), and the regional councils charter the local councils (which is taking place at the time of this plan). The ICCMH will also lead the effort in the development of an annual children's mental health community report card that will make the data on gaps in service, utilization of services and may include indicators on performance, available to stakeholders and the community. The first draft of the Community Report Card was completed in December of 2002 and was distributed to the Governor, the Legislative and other stakeholders of the system of care.

3. Building on Each Other's Strengths: Cooperative Agreement with SAMHSA

As previously mentioned, Idaho has been awarded a Cooperative Agreement from SAMHSA for building community based systems of care. Idaho has titled the Cooperative Agreement project "Building on Each Other's Strengths." Idaho has determined that the best use of the Cooperative Agreement funds is towards building a system of care for the entire state, not a single community, county or region. The funds will be used to build the infrastructure for a statewide system of care, but will not be used to temporarily inflate services offered by the system. A priority of the project is to create a single vision around children's mental health, including: the need of the system to be child-centered and family-focused, to ensure that providers that serve

children and families all recognize the need to include and empower the family, the need to collaborate, and that services need to be culturally competent.

B. GOALS, OBJECTIVES, PERFORMANCE INDICATORS

GOAL #3: **ENSURE A SYSTEM OF INTEGRATED SOCIAL SERVICES, EDUCATIONAL SERVICES, JUVENILE CORRECTIONS SERVICES AND SUBSTANCE ABUSE SERVICES TOGETHER WITH MENTAL HEALTH SERVICES, SUCH THAT CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE AND THEIR FAMILIES CAN RECEIVE CARE APPROPRIATE FOR THEIR MULTIPLE NEEDS.**

Objective 3.1 **Local councils will be established and will staff and coordinate care for youth and families served by the council.**

Population:	Children with SED
Criterion:	Comprehensive community based services for children
Brief Name:	Local Council services
Indicators:	Percentage of children that were staffed at a Local Children's Mental Health Council.
Measure:	
Numerator	Number of children for whom a local council held a staffing.
Denominator	Total number of children served by CFS
Sources of Information:	Local Councils and FOCUS, CFS information system
Special Issues:	The court-approved plan calls for the establishment of seven local councils by March 1, 2002. Establishment will mean that local councils have agreements in place and have the ability to staff cases. Local councils will provide the method for coordinating and collaborating across agencies for the child's care. Children referred to the local council will be involved in more than one child-serving agency. The number of youth served will be measured over time. This is the first year of local councils in each area of the state. Increases in number of youth served by local councils can be monitored over time.
Significance:	Interagency collaboration at the local level will ensure a comprehensive community based system of care for children. This objective relates to the State Planning Council's CMH priority: *Expand and refine collaboration and remove barriers to coordination.*

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. Percentage of children receiving services from the Department that were staffed at a Local Children's Mental Health Council.	2 %			
Value:				
Numerator: Number of children for whom a local council held a staffing. **Denominator:** Total number of children served by CFS.	___94____ __3870___	_____ _____	_____ _____	_____ _____

CRITERION 4

TARGETED SERVICES TO HOMELESS AND RURAL POPULATIONS: The plan provides for the establishment and implementation of a program of outreach to and services for individuals with SMI or SED who are homeless; and additionally describes the manner in which mental health services will be provided to individuals residing in rural areas (previously Criteria 8 and 10).

A. NARRATIVE

1. SERVICES FOR HOMELESS RUNAWAY YOUTH

A survey of Idaho's primary homeless and runaway youth programs identified the following as the major mental health needs of runaway and homeless youth:

- Family conflict situations;
- Depression;
- Suicide ideation;
- Substance abuse; and
- Trauma associated with history of physical and/or sexual abuse.

Children who are homeless and youth with serious emotional disturbance comprise two broad groups: (1) those who have no family, including runaways or those discarded from their families; and (2) those youth that have families but whose parents are themselves homeless.

Each of these two broad groupings of homeless youth, those living with family and those living apart from family, can access needed mental health services through a number of pathways. However, traditionally the service system has had difficulty providing accessible mental health and other related services to this population. The following are initiatives and projects that the Department either sponsors or has linkages with in order to provide outreach and access to homeless youth with serious emotional disturbance.

a. Crisis/shelter system

Idaho has few homeless shelters. Those that do exist are clustered around larger communities; i.e., Boise and Pocatello, and most serve primarily adult males. In Boise, Idaho's capital city, there are a few shelters that provide housing to families. These shelters have access to mental health services for families and children provided by the Department of Health and Welfare, Children and Family Services' offices through established referral and intake mechanisms and through the shelter home's own service provider.

There are two federal funding grantees within the state system that provide a variety of services to homeless/runaway youth: the Bannock Youth Foundation in Pocatello and Hays Shelter Home in Boise. Besides providing crisis and emergency shelter, both offer a variety of in-house, short-term and crisis mental health services to their client population. When necessary, these programs refer clients to the local Family and Children's regional office for more intensive mental health services. Additionally, local Children and Family Services' offices contract with these two agencies for various services, such as shelter care and family reconciliation.

Several communities have domestic abuse shelters that serve women and their children. Many of these women have mental health needs of a crisis nature. Depending upon the shelter, there may be limited in-house capacity to address mental health crisis needs. The Department of Health and Welfare, through its Children and Family Services program, serves the more intensive and/or longer term mental health needs of this population. These services are accessed through the emergency response system or by the shelter making a referral through established mechanisms.

b. Community Mental Health Emergency Response System

In Idaho, the most frequently occurring entry point for mental health services for homeless youth is through the crisis system. The Department of Health and Welfare, Children and Family Services, maintain statewide emergency systems. The Department facilitated the development of Emergency Response protocols that cover every region of the state. Community agencies that have contact with homeless youth needing mental health services frequently access these emergency services. The various community agencies that serve the homeless have ready access to emergency mental health services.

c. Community Agencies

Various community agencies, in addition to Children and Family Services, come into contact and identify homeless youth in need of mental health services. These include county social services, crisis/emergency shelters, emergency rooms, schools, Community Action Programs, and Health and Welfare eligibility determination offices.

d. Community Action Program (CAP) offices exist throughout the state in all seven Health and Welfare regions. The State Economic Opportunity Office allocates federally derived funds to each CAP for identified homeless clients.

e. Community-based hospital emergency rooms are a frequent point of access for crisis services for the homeless youth and his/her family. The public emergency mental health system, Children and Family Services, networks and links with this hospital resource. Community hospitals work in conjunction with their local Children and Family Services' office to provide mental health services when they have identified homeless youth with mental health needs.

f. County Social Services refer identified homeless clients to their local regional Children and Family Services' offices for children's mental health services.

g. The Department of Health and Welfare has statutory responsibility to provide child protective services for the state. As previously mentioned, the Department delivers child protective services through the Children and Family Services Program, the program that also delivers children's mental health services. When a child protective services worker identifies a homeless youth with mental health needs, mental health services are offered within the same program.

The Department of Health and Welfare co-locates eligibility offices with its regional Children and Family Services offices in all regions of the state. When families apply for services and assistance for their family/children and it is determined that they are homeless and that a child in the family has a mental health need, a referral for child mental health services is made in-house.

h. Churches may identify homeless families who have children experiencing mental health difficulties. Church authorities know how to refer and access their local Children and Family Services' office for screening and service need.

i. Community House Program

In Boise, all the major community agencies serving the needs of the homeless population have formed The Homeless Coalition. The Department of Health and Welfare, through its Region IV service center, has been an essential member of this group. This lead group helped to create Community House. Community House is designed to be the central access point for homeless families in the Treasure Valley and provides a full service program. Community House offers shelter to homeless families as well as having on site treatment and case management is provided as part of the program. Case managers help coordinate and access other identified services as part of a client's plan. The services may include job training, childcare, social services, mental health services, and medical services to homeless families. With the development of Community House, services for the homeless population are more easily accessed. Community House is an example of a locally based partnership that is funded by a blending of private and public resources. Included are on-site mental health screenings for clients in the shelter and availability of mental health services as indicated by the screening.

j. Region III contracts with the Idaho Commission on Hispanic Affairs to provide information and assistance to Hispanic families about accessing services provided though the

Department of Health and Welfare and through community providers. The liaisons provide education and assistance in accessing all Department services including children's mental health. This affords the opportunity to provide more culturally relevant services than the regional service office could offer through its own internal resources.

2. SERVICES TO INDIVIDUALS RESIDING IN RURAL AREAS

Idaho is primarily a rural state. Low population densities in many service areas make it impractical to dedicate large amounts of resources/funding on predetermined categorical programs, which may only be indicated for a few individuals. This is especially true for programs such as inpatient and residential, which require large amounts of "up-front" resources to develop and support the program.

The availability of professionally trained staff is very limited in many areas of Idaho. In the more rural areas of the state, families and children are less likely to have access to trained mental health professionals. Recruiting and maintaining staff is also a difficult task for the Department as well as private providers and agencies.

An additional complication for the service delivery system is that the incidence of poverty is greater in Idaho's highly rural areas. Since the percentage of families living in poverty is high, private sector treatment providers avoid investing resources and provide few services in such areas due to the decreased potential for covering their incurred costs. Consequently, service delivery in rural areas becomes the primary responsibility of the public service sector.

In large expanses of rural area, distances and lack of transportation can become barriers to service access. It is not practical to have a full service office in every small town. The Department does maintain offices in most counties. In order to best provide access to services at the local level and to make services available in rural areas, the Idaho Department of Health and Welfare has decentralized its service delivery system by organizing into seven service regions. Each of the seven service regions is subdivided further to facilitate localized service capacity. The Division of Family and Community Services maintains a total of 33 service centers, field offices and satellite offices throughout the state system (Appendix B).

Recognizing the needs of children and families living in rural and frontier geographic areas of the state, the Department has developed core service standards. The standards are intended to achieve statewide consistency in the development and application of CMH Core services and shall be implemented in the context of all applicable laws, rules and policies. Regardless of the rural nature of the community that the child lives, the intent of the standards is to ensure that the array of services are available to all Idaho children and families that need the service. While all these services cannot be available in every community of the state, each regional service center is required to build the capacity to meet the need of their region.

B. GOALS, OBJECTIVES, PERFORMANCE INDICATORS

GOAL #4: **ENSURE THAT FAMILIES RESIDING IN RURAL AREAS HAVE ACCESS TO SERVICES FOR THEIR CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE.**

Objective 4.1 **Twenty five percent of children served by Department programs are from rural areas.**

Population:	Children with SED
Criterion:	Services to rural and homeless populations
Brief Name:	Services to rural and homeless populations
Indicators:	The percentage of children receiving publicly funded services that reside in rural areas. The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located. This is determined by factoring out from the total of children served within the system, the number of children served in Idaho's seven most populated counties: Kootenai, Nez Perce, Canyon, Ada, Twin Falls, Bannock, and Bonneville.
Measure:	
Numerator	The number of children/youth served from rural areas.
Denominator	The total number of children/youth served across all counties/field offices.
Sources of Information:	Divisional information systems and Medicaid database.
Special Issues:	The figures reflecting numbers of children served represent both those youth receiving community-based services through DHW's regional programs and youth receiving Medicaid-funded services through the private provider service sector. Children receiving PSR services are SED. The percentage youth included in the above figures who are served by Medicaid clinic option in the private sector and who meet serious emotional disorder eligibility criteria are not known. The most that the Medicaid data system can provide is a diagnosis, and diagnosis alone is not sufficient to determine serious emotional disorder.
Significance:	Idaho is a very rural state. A large percentage of Idaho citizens reside in rural areas. It is important for citizens that they have access to services in rural areas. Rural service delivery is a requirement of federal law if states are to receive federal block grant monies. This objective relates to the State Planning Council's CMH priority: *Increasing services, increase continuous access to these services and removal of barriers in rural areas of the state.*

	FY 2001 Actual	FY 2002 Projection	FY 2003 Objective	% Attainment
Performance Indicator: 1. The percentage of children receiving publicly funded services that reside in rural areas. The number of children served in a rural service area is defined as those children served from counties and field offices other than the county in which the primary regional service center is located. This is determined by factoring out from the total of children served within the system, the number of children served in Idaho's seven most populated counties: Kootenai, Nez Perce, Canyon, Ada, Twin Falls, Bannock, and Bonneville.	41 %		25 %	
Value:				
Numerator: The number of children/youth served from rural areas.	__1332___	_____	_____	_____
Denominator: The total number of children/youth served across all counties/field offices.	__3870___	_____	_____	_____

CRITERION 5

MANAGEMENT SYSTEMS: The plan contains a description of the financial resources, staffing and training necessary to implement the plan, including programs to train individuals as providers of mental health services, with emphasis on training of providers of emergency health services regarding mental health. Also, the plan describes the manner in which the state intends to expend the grant for the fiscal year involved to carry out the provisions of the plan (previously Criteria 5 and 12).

A. NARRATIVE

1. FINANCING AND RESOURCE SUPPORT

Current efforts to provide children's mental health services are fiscally integrated with other FACS programming. Whenever feasible, non-dedicated funds are pooled. The resulting social service cost pool is used to fund a variety of needed services, including children's mental health services. Within the FACS budget, there are few line items specific to children's mental health. Consequently, it is exceedingly difficult to identify and track funds specifically targeted at children and adolescents with serious emotional disorders and their families. In the Department's present configuration, the target population can be served by entering the system through several referral pathways. Therefore, children who meet the target population definition can receive services that focus on their needs and the needs of their family. Providing services in this way enables a more flexible use of available funding, reducing gaps and overlaps in the process and providing the opportunity to serve more of Idaho's population in need of service.

The Division has received annual legislative funding of $6,757,100 in general funds, as dictated by the Jeff D. lawsuit settlement. These funds are specifically intended for development of community-based services for children and youth with serious emotional disorders. The Division's total projected funding for children's services programs for SFY2004 is $54,531,600. This amount can be broken down into funding sources as follows:

Social Services Block	$ 5,471,700
State General Funds	$21,097,300
Receipts	$ 556,500
IV-B CWS (Child Welfare Services)	$ 1,764,720
IV-E Funds (Foster care)	$ 5,215,300
IV-E Adoption	$ 2,219,400
TANF/Emergency Assistance	$11,944,700
MH Block Grant (10%)	$ 321,667
Child Abuse Prevention (NCCAN)	$ 13,500
IV-B Promoting Safe & Stable Families	$ 1,108,900
Independent Living	$ 561,200
Children's Justice Act	$ 83,500
Children's Mental Health Initiative	$ 972,200
Miscellaneous	$ 3,201,013
Total	$54,531,600

This level of funding provides for personnel, operating, and other expenses to support residential care systems, foster care services, and community-based services by the Department. The above information does not include the budgetary expenditures of the State Hospital South Adolescent Unit, which is an additional $2,408,300.

The estimate of the amount of funds to be spent on children's clinical services (including direct charged Jeff D. and Trustee/Benefits) in SFY2004 is as follows:

Medicaid Receipts	$ 163,800
SSBG/General Funds	$5,325,700
Total	$5,489,500

2. STAFFING OF THE SYSTEM

The legislature authorized the addition of 10 clinicians for fiscal year 2003; however, due to a lagging state economy and lower than expected state revenues during FY 2002 and 2003, the children's mental health program realized a reduction in CMH clinicians by 12.5 positions. There are currently 65 fulltime positions dedicated to the provision of clinical services to children and youth with serious emotional disturbance. These positions do not include staffing of the State Hospital Adolescent Unit. Appendix H shows the statewide distribution of clinician staff devoted to children's mental health services within the regional service programs. Many of these staff also has administrative and/or supervisory responsibilities. Such duties, while essential, decrease the amount of time these staff are available to perform direct services.

3. TRAINING FOR FAMILIES AND PROFESSIONALS IN THE SYSTEM

The Department has made a significant effort in the last year to increase the training necessary to ensure that staff, private providers, partner agencies and families have the necessary knowledge and skill to effectively perform the function of their duties. Below is a list of activities intent to improving services to children and families in the state. (This is not an exhaustive list of activities, but examples of activities DHW is using.)

- The Department maintains a new worker academy for social workers and clinicians. The academy typically occurs three times a year and focuses on basic ethics, governance bodies, the system of care, information related to the emergency service system, family centered practice, cultural competence, and variety of other philosophical and functional areas.
- The children's mental health program has recently drafted a set of core competencies that guide new and journeyman staff in identifying training needs. Related to these competencies, the Department's children's mental health program specialist provided training and technical assistance in every region of the state related to the core service standards and system of care philosophy.
- The Department maintains a contract with the Idaho Child Welfare Research and Training Center for organizing and providing training to the Child Welfare and Children's Mental Health staff.
- FACS Policy Memorandum 01-03 requires that all children's mental health staff receive training annually by parents and family members of children with serious emotional disturbance. This training helps staff to recognize the challenges that families have to struggle with everyday.
- The Department is currently in the RFP process of contracting with a parent-run organization for family support and advocacy in Idaho. The contract will require the contractor to provide ongoing training to staff and families served by the Department on advocacy, self-case management and consumer training.

- The previously mentioned Building on Each Other's Strengths cooperative agreement provides Idaho with an opportunity to receive technical assistance from nationally recognized experts in a variety of areas including cooperative service planning, cultural competence, family-centered practice, etc.
- Individuals from the Department, the State Planning Council on Mental Health, and NAMI have provided training to the police academy on issues that pertain to mental health law and respective treatment of individuals with mental illness among others.
- Private providers of mental health services were provided training on assessment and services planning and trained on the CAFAS in every region of the state.
- Training has been delivered to emergency mental health responders on how to assess for needs, safety planning, and community referrals. Training also includes how to conduct Designated Exams for determining if involuntary treatment is necessary.
- Idaho has been sending a team of parents, advocates, juvenile justice staff, legislators, clinicians, leaders and a researcher to the system of care conferences to gather and share information on current treatment and research on children's mental health issues.

4. DATA AND INFORMATION SYSTEM DEVELOPMENT

The Division has completed implementation of its Family Oriented Community User System (FOCUS) information system. The first phase of this implementation began July 1, 1998, in Region V. Staff training and conversion of cases from the old data system took place region by region. The system was fully implemented October 1, 2000. The FOCUS information system is an electronic system including an electronic clinical record. This system encompasses child protective services, child mental health services, foster care and licensing, adoptions, interstate compacts, as well as invoicing and payment for child welfare and children's mental health services. This system will provide the information on the number of children and the resources used through the CFS program. The FOCUS system has the capability to report on a number of data elements reported in this plan. Idaho is working to enhance this system to report on all of the elements required for the implementation plan and has received the Data Infrastructure Grant to assist in this enhancement. The FOCUS system is anticipated to have the ability to report the Uniform Data requirements as the MH Block Grant becomes a Performance Partnership. The only required element that is currently not tracked is the rate of homelessness. However, prior to the start of FY2004, the system will be modified and homelessness will be recorded ongoing.

Additional data is gathered through the Medicaid fiscal system (AIMS) and a database that contains service evaluation information (the Service Evaluation Database). The AIMS system was developed for fiscal purposes and is also used to extract data on utilization and expenditures. The service evaluation database will be integrated into the FOCUS system, but was created separately to ensure its timely completion. The Service Evaluation Database contains data on the Family Satisfaction Surveys gathered every 120-days from families and the CAFAS outcomes information.

5. QUALITY ASSURANCE AND PROGRAM ACCOUNTABILITY

A number of efforts and activities are occurring to help initiate and continue assuring program accountability, outcomes and quality assurance/improvement. FACS is currently implementing a

Continuous Quality Improvement system in the Children's Mental Health Program. This system has three (3) major components:

- External Reviews
- Internal Reviews
- Case Reviews

The Department, with the intent to become more proficient at conducting uniform assessments with measurable outcomes, has begun using the Child Adolescent Functional Assessment Scale (CAFAS) as a statewide uniform assessment tool. CAFAS scores are recorded in a data base to track progress of the child's functioning over time. The CAFAS is administered initially at application for services for eligibility purposes and every 120-days as an outcomes measure. The CAFAS is assisting the Department in measuring the success of our own services and our service providers.

The Children and Family Services program continues to emphasize the need for program evaluation that includes input and feedback from families. All families receiving services have the opportunity to complete a Family Satisfaction Survey. Families are given the opportunity to provide feedback in a voluntary and confidential way in the following categories.

- Access
- Appropriateness
- Inclusion/Empowerment
- Effectiveness

The information and data gathered will be added to overall system evaluation efforts. Input from families and family advocacy organizations (such as The Idaho Federation of Families for Children's Mental Health) is also invaluable in assisting with planning of the mental health service system. Parents and advocates input is gathered through their involvement in policy and program development.

The Department has a contract with the Idaho Child Welfare Research and Training Center of Eastern Washington University to assist in the evaluation of the Regional and Local Children's Mental Health Councils. The evaluation will look at individual and system outcomes for those served through the council. This information will then be used in evaluation of the local councils.

The Children's Mental Health Subcommittee, a standing committee of the State Planning Council on Mental Health, plays a role in monitoring the adequacy of the mental health system for children. It also assists in establishing the system priorities and monitoring of the system's responsiveness to those priorities.

Medicaid Rehabilitation Option is developing the process to collect information regarding outcomes and assist families in selection of providers. The data will be used for comparison purposes to aid in determining client outcomes and service effectiveness as part of each Regional Mental Health Authority's Quality Assurance Plan. The Children and Family Services program

recognizes that this outcome and service evaluation data is needed for all children and families receiving publicly funded services, not just those receiving services under the Rehabilitation Option. Client evaluation will focus on the 8-scales of client functioning specifically identified on the CAFAS.

6. SAMHSA BLOCK GRANT EXPENDITURE FOR CHILDREN

The Children's and Family Services budget contains very few specific children's mental health line items. The funding for community-based mental health services is consolidated into a social service cost pool. This includes Child Welfare funds, Social Service Block Grant Funds, TANF funds, Title IV-E funds, Medicaid funds, and state general funds. No institutional, residential care or group care expenditures are included as part of this budget. Costs are charged to the budget based on the Division's Random Moment Time Study (RMTS) completed by staff in the field. The following information represents children's mental health expenditures for SFY2003.

TOTAL RMTS COSTS FOR SFY2003:

SFY2003	ALLOCATED EXPENDITURES
Total	$2,776,400

CMH RMTS COSTS BY FUNDING SOURCES:

Mental Health Block Grant	$ 112,298
Medicaid Receipts	$ 157,200
Federal/General Funds	$2,506,902
Total	$2,776,400

TOTAL EXPENDITURES FOR CMH FOR SFY2003:

Mental Health Block Grant – Cost Pool	$ 112,298
Mental Health Block Grant	$ 21,236
Child Clinical Receipts	$ 157,200
Federal/General Funds	$10,492,666
Total	$10,783,400

The above information shows how the state loaded the 2002 SAMHSA block grant funds into its budget structure. This assures that all block grant funds pertaining to children's mental health obtained through SAMHSA and in accordance with PL 102-321 was expended for community-based programming. Loading the SAMHSA block grant funding into the social service cost pool ensures that the dollars will be used across all service regions to help fund the community-based system of care. Specifically, these dollars will go toward funding a small percentage of case management staffing and outpatient treatment services. The Department will continue to

allocate $111,667 of block grant to the children's portion of the cost pool. An additional $155,000 of block is being allocated for contracting with a family run organization for family support and advocacy. The remaining $55,000 is being used to assist families with access to respite care.

B. GOALS, OBJECTIVES, PERFORMANCE INDICATORS

GOAL #5: **PRIORITIZE FUNDING FOR COMMUNITY-BASED SERVICES TO ENSURE APPROPRIATE RESOURCE ALLOCATION OF THE COMMUNITY-BASED SYSTEM, AND TO ENSURE CONTINUOUS QUALITY IMPROVEMENT OF THE SERVICE SYSTEM.**

Objective 5.1 **75% of all funding for children's mental health services will be spent on community based services.**

Population:	Children with SED
Criterion:	Management Systems
Brief Name:	Expenditures on community-based programs
Indicators:	Percentage of total children's mental health funding, including block grant funds, expended for community based services.
Measure:	
Numerator	Amount of children's mental health funding for community based programs (non-hospital care and expenditures).
Denominator	Total funds spent on all children's mental health services including State Hospital South and other hospitalizations funded by Medicaid or contracts.
Sources of Information:	Divisional information systems, Division of Management Services information systems, and Medicaid system information.
Special Issues:	Many/most hospitalizations are most appropriately considered community-based, especially if the hospital is located in the child's home community and if the admission is for short-term crisis stabilization. However, in Idaho, many of the inpatient units receiving public funds (Medicaid) are long distances from the child's home and some of the stays are longer than short-term crisis stabilization. The data system cannot differentiate which admissions may be local and short term versus distant and longer term. Subsequently, for purposes of this performance indicator, community-based services are defined as outpatient services that clearly are community-based and are less restrictive.
Significance:	A community-based service system is a core value for the state as well as being a standard for the field. Community-based services have been shown to be the most normalized, the most effective and the most cost efficient services. Data systems are needed which address not only client encounter and funding data parameters, but also quality and

	service effectiveness measures. This objective relates to the State Planning Council's CMH priority: *Enhancing community-based efforts at all levels within the community.* .

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. Percentage of total children's mental health funding, including block grant funds, expended for community based services.	82 %		75 %	
Value:				
Numerator: Amount of children's mental health funding for community based programs (non-hospital care and expenditures).	$32,851,186	_____	_____	_____
Denominator: Total funds spent on all children's mental services including State Hospital South and other hospitalizations funded by Medicaid or contracts.	$39,646,470	_____	_____	_____

Objective 5.2 **The Adult and Children's Mental Health Programs will develop and provide joint training on the provision of mental health services to children with SED and adults with SPMI for Healthy Connections primary care physicians during FY 04.**

Population:	Children with SED
Criterion:	Management Systems
Brief Name:	Training for primary care physicians
Indicators:	Training is developed and provided
Measure:	
Numerator	
Denominator	
Sources of Information:	Self Report
Special Issues:	
Significance:	This objective corresponds with the New Freedom Commission Recommendation 1.2 which recommends addressing mental health with the same urgency as physical health. This objective relates to the State Planning Council's CMH priority: *Public education to promote awareness.*

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 1. Number of trainings provided to primary care physicians.	0			
Value: Number of trainings provided to primary care physicians.	0			
Numerator: **Denominator:**	_____ _____	_____ _____	_____ _____	_____ _____

ADULT PLAN FY 2004

PLEASE NOTE:

1. Any data in the Adult Plan represents our best estimates based on available data and reflects the limitations of our reporting and information systems. In some cases it is not possible to guarantee unduplicated counts. We are currently in the process of changing to a new data collection system in order to meet the MHSIP requirements. Due to this change, we will be required to establish new baseline measures for most performance indicators during this FY as our existing data is not comparable or transferable to the new data system. Idaho will begin collecting all required MHSIP data elements beginning October 1, 2003.

2. We used 7/1/03 as the effective date in listing data, providers, resources and facilities in operation. Data reported in the plan is based on the state fiscal year.

3. We have generally adopted an approach of "maintain effort rather than expect to increase effort." We believe this to be a realistic approach based on our available financial resources, the growing state population and corresponding increase in demand for services, and projected major service delivery system changes in FY2004.

4. In Idaho, Due to funding constraints, the target population is *serious and persistent mental illness*, a narrower subset of serious mental illness.

NARRATIVE, GOALS, OBJECTIVES AND INDICATORS

CRITERION 1

COMPREHENSIVE COMMUNITY BASED MENTAL HEALTH SERVICE SYSTEMS:
Establishment and implementation of a community-based system of care for adults with serious mental illness (SMI) and children with a serious emotional disorder (SED), describing all available services including health (medical and dental), mental health, rehabilitation, case management, employment, housing, educational, other support services, and activities to reduce the rate of hospitalization of individuals with SMI or SED.

A. NARRATIVE

1. ORGANIZATIONAL FRAMEWORK

- **Service Model for Adults**

Public services to adults with serious mental illness in the State of Idaho are provided primarily through a network of seven state operated regional community mental health centers and two state hospitals, State Hospital South in Blackfoot and State Hospital North in Orofino. System support is provided by the Division of Family and Community Services. A developing private sector throughout the state is also serving the state's target population.

- **Family and Children's Services Mental Health/ Developmental Disabilities Field Operations Team**

New structure was put in place as part of the overall realignment and consolidation of the Department of Health and Welfare to improve accountability, consistency and efficiency in lines of authority and responsibility for the Division of Family and Community Services (FACS). Lines of authority have been realigned to directly connect the regional programs with the FACS Division Administrators. Responsibility for program budgets, policy development and implementation and quality assurance has been shifted from the Regional Directors to the Division Administrators. The seven regional Mental Health/ Developmental Disability Program Managers now report to the Division Administrator. In addition to the Division Administrator, there are two Deputy Administrators, one responsible for Field Operations dealing with the regional programs and one responsible for Program Operations over the central office programs in the Division.

The seven regional adult mental health/ developmental disability program managers, the administrative directors of the two state hospitals, the FACS Division Administrators, the Mental Health Program Manager, Substance Abuse Program Manager, and two Developmental Disabilities Program Mangers constitute the newly reorganized FACS MH/DD Field Operations Team. The team meets on a monthly basis and is a primary vehicle for system coordination, policy development and system improvement.

- **Adult Mental Health Program**

The FACS Division Adult Mental Health Program consists of one program manager, two program specialists and one administrative assistant. The program was previously located in the Bureau of Mental Health and Substance abuse in the Division of Family and Community Services. In conjunction with the realignment activities of the Department the FACS bureaus were separated into individual programs. There is also a Substance Abuse Program within FACS. The Division programs provide system leadership, consultation, technical assistance, and training. The Adult Mental Health Program supports system improvement (including the areas of system coordination, consumer and family member empowerment) the development of policies and best practice procedures, overseeing federal grant applications and contract development and monitoring. Contracts administered by the Division include those with NAMI-Idaho, the Office of Consumer Affairs and the Division of Vocational Rehabilitation.

- **Community Mental Health Centers**

Idaho's seven regional community mental health centers (CMHC's) have primary responsibility for the development of a system of care that is both community-based and consumer-guided. Each CMHC has a Regional Mental Health Advisory Board consisting of interested citizens, consumers and advocates. These groups meet regularly and provide important input and recommendations for improvement of the mental health delivery system.

The seven regional mental health centers are designated the role and responsibility of Regional Mental Health Authorities (RMHA's) in the prior authorization of psychosocial rehabilitation services. In response to mandated budget holdbacks, significant changes in the prior authorization activities of the Region Mental Health Authorities were implemented in FY 03. RMHA staff in each of the seven regional CMHC's was decreased to one person per region. A new procedure was implemented transferring psychosocial rehabilitation assessment and service planning to private sector providers. The RMHA's responsibilities now include review and prior authorizing requested services. This change was made in an effort to respond to require budget reductions by reducing administrative activities as opposed to reducing direct services.

- **State Hospitals**

The Division of Family and Community Services is responsible for the administration of the two state psychiatric hospitals, State Hospital North (SHN) and State Hospital South (SHS), and the Idaho State School and Hospital (ISSH).

2. INTEGRATED THEORETICAL MODELS OF TREATMENT AND SERVICE DELIVERY

- Much work has been done in recent years to adapt our adult mental health treatment models to more effectively serve the target population of persons with serious and persistent mental illness. *Assertive Community Treatment* Teams are in place in all seven regions. All regions provide *24-hour community crisis response,* with five regions operating designated *Crisis Response Teams. Case Management* is provided to all persons enrolled in the public adult mental health service system.

- Idaho has made significant progress in developing its Community Support Program for adults with serious mental illness. Psychosocial Rehabilitation (sometimes known in the literature as Psychiatric Rehabilitation) continues to be our treatment modality of choice in serving the target population. Psychosocial Rehabilitation enables treatment to be provided in the client's normalized settings of home, work and community.

- Another recent treatment innovation in our state has been the development of dual diagnosis (or "co-occurring mental illness and substance abuse") services for persons who are experiencing both serious mental illness and substance abuse. National studies estimate that between 50% and 70% of persons with serious mental illness also have a substance abuse

problem. Several regional community programs, most notably Regions III, V, VI and VII, continue to offer services targeted to those individuals with a dual diagnosis.

- In an ongoing effort to provide alternatives to psychiatric inpatient hospitalization in Idaho's largest metropolitan region (Region IV, headquartered in Boise) has developed Franklin House, an 8-bed community-based crisis residential facility. This facility provides a safe, secure, and supportive environment for individuals experiencing psychiatric crisis but not requiring extended hospitalization. Other DHW regions are exploring ways to implement crisis residential programs using similar program models.

- Another recent innovation has been the establishment of a Mental Health Court in Region VII. The Idaho mental health court is a voluntary program for persons who have a severe and persistent mental illness and have pleaded guilty to crimes, both misdemeanor and felonies. In, order to participate in the program the consumer must be accepted and must agree to participate in active treatment for the mental illness. While engaged in active treatment the jail sentence is suspended. The program is set up in four phases lasting a minimum of 40 weeks. The court is an intensive and collaborative effort between the judges, prosecutors' office, public defenders office, probation officers, substance abuse treatment providers, jail representatives, NAMI, and the CMHC's Assertive Community Treatment team and Crisis Team.

3. SYSTEM COORDINATION

- **Consumer and Family Member Empowerment**

We are committed to providing quality systems of care to adults with a serious mental illness in the state of Idaho. To this end, the Division of Family and Community Services and the CMHC's maximize opportunities for input from:

- The Idaho State Planning Council on Mental Health
- Regional Mental Health Advisory Boards (RMHAB's)
- The National Alliance for the Mentally Ill, Idaho Chapter
- The Mental Health Association of Idaho (MHAI)
- The Idaho Office of Consumer Affairs and Technical Assistance
- Local consumer and family member self-help groups

- **Collaboration with Community Providers and Other Agencies**

In an effort to provide the best quality services in a climate of limited resources, staff in the regional CMHC's recognize the need to work collaboratively with other agencies. Regional CMHC's offer education and consultation services regarding mental health issues and services. They also work to develop multi-agency task forces and partnerships with law enforcement, hospitals, counties, housing providers and other agencies to resolve concerns and maximize resources. The Medicaid Psychosocial Rehabilitation Option continues to provide opportunities for partnerships between the regions and private sector providers.

- **Coordination with State Hospitals**

Idaho's two state hospitals, State Hospital South (SHS) in Blackfoot and State Hospital North (SHN) in Orofino, collaborate and coordinate with CMHC's to ensure a seamless, efficient delivery system of public mental health services, as follows:

a. SHN assigns a primary therapist for each client admitted to the hospital. The primary therapist is responsible for initiating weekly telephone contacts with regional CMHC staff to give progress reports, coordinate care, update discharge plans and arrange aftercare services.

b. SHS staff initiates monthly conference calls with all regional CMHC's who have clients admitted or in residence during the month. Content of the calls includes progress reports, treatment planning, discharge planning, and aftercare discussions.

c. Every Regional CMHC has an identified *Hospital Liaison* who maintains regular contact between the institutions and the community programs. These Hospital Liaisons and their Regional Program Managers meet in Boise with staff from both state hospitals every six months to review admission and discharge protocols, discuss barriers to community placement and consider system issues of mutual concern. These meetings also make recommendations for service system improvement, identify areas for resource development, and discuss ongoing continuous quality improvement projects. (One such continuous quality improvement project is an initiative to improve communication and cooperation between the state hospitals and the CMHC's.)

d. Monthly and annualized utilization data are reviewed by the FACS MH/DD Field Operations Team at their monthly meetings. These data include regional admission and discharge rates and regional hospital bed utilization patterns. Regional rates of discharged clients successfully keeping their first CMHC appointment and the 30-day readmission rates are also regularly shared and reviewed. In addition, problem cases identified as having barriers to prompt and/or successful community placement are reviewed at these meetings.

e. State Hospital Staff participates as equals at all levels of service system planning and development. The administrative directors of SHN and SHS regularly attend the meetings of the State Planning Council on Mental Health.

4. DESCRIPTION OF AVAILABLE RESOURCES AND SERVICES

This section will describe three broad categories of services available in the state of Idaho to adults with serious mental illness:

- State Provided Community Mental Health Services
- State Hospital Services
- Private Sector Mental Health Services

· **State Provided Community Mental Health Services**

The following is a description of the "core" adult mental health services that are provided by all seven regional community mental health centers. Please see Appendix B for a map of Idaho showing the regional CMHC's and their field offices.

a. Population Served:
We serve any individual 18 years of age or older who has a severe and persistent mental illness and who meets the following two criteria:

(1) The individual must have a diagnosis under DSM-III R or DSM-IV of schizophrenia, schizo affective disorder, major affective disorder, delusional disorder or a borderline personality disorder; and,

(2) This psychiatric disorder must be of sufficient severity to cause a disturbance in role performance or coping skills in at least two of these areas on either a continuous or an intermittent (at least once per year) basis: Vocational/academic, financial, social/interpersonal, family, basic living skills, housing, community or health.

In addition to the above population, we also serve:

Any individual 18 years of age or older who is experiencing an acute psychiatric crisis, including suicidal and/or homicidal behavior and who may end up in an inpatient psychiatric facility if mental health intervention is not provided promptly. Only short-term treatment or intervention, not to exceed 120 days, is provided to this population.

b. Core Mental Health Services:

(1) Screening
(2) Targeted Case Management
(3) Crisis Intervention
(4) Psychiatric Rehabilitation
(5) Assertive Community Treatment
(6) Psychiatric Services
(7) Short-Term Mental Health Intervention

c. Description of Core Services:
(1) Screening: Screening for eligibility of services through Regional Mental Health Programs based on the above criteria. If an individual meets population criteria as defined above, he or she is accepted for services either on an ongoing basis or for short-term intervention. Individuals not meeting above criteria are referred out to appropriate community agencies.

(2) Targeted Case Management Services: Targeted case management services are provided to severely and persistently mentally ill clients who meet our first criteria outlined above. Services include:

(a) Comprehensive psychosocial assessment

(b) Treatment plan development
(c) Monitoring and coordination of service delivery
(d) Linkage with requisite services
(e) Client advocacy
(f) Direct assistance with symptom management

(3) Crisis Intervention Services: These services provide for the delivery of both center-based and community-based crisis intervention in psychiatric emergencies, including 24-hour telephone crisis intervention services. Community emergency resources and providers are mobilized in order to stabilize the crisis situation and to provide immediate and/or continuing treatment.

(4) Psychiatric Rehabilitation Services: Psychiatric Rehabilitation Services are outcomes oriented and are provided to assist consumers in functioning maximally in community settings within the limits of their disabilities. Services include:

(a) Individual psychiatric rehabilitation
(b) Group psychiatric rehabilitation
(c) Pharmacological management
(d) Nursing services
(e) Other rehabilitative treatment including skill acquisition:
    i) Independent living skills (cooking, cleaning etc.)
    ii) Symptom management
    iii) Leisure skills
    iv) Health and nutrition
(f) Housing
    i) Placement and support
    ii) Limited financial support to prevent homelessness
(g) Vocational
    i) On-site vocational counselor
    ii) Community supported employment

(5) Assertive Community Treatment: An intensive case management program delivered by the use of assertive outreach to the community. The majority of treatment and rehabilitation intervention takes place in the community in the consumer's natural environment. The services include:

(a) Direct assistance with symptom management
(b) Medication monitoring
(c) Assistance with meeting basic needs
(d) Assistance with supportive social environment
(e) "In vivo" skill teaching
(f) 24 hour crisis availability
(g) Assistance in vocational reintegration
(h) Financial monitoring

(6) Psychiatric Services: These services include:

(a) Psychiatric evaluation
(b) Medication prescription
(c) Medication monitoring
(d) Consultation and education
(e) Psychiatric nursing

(7) Short-Term Mental Health Intervention: Short-Term mental health treatment is provided to an individual 18 and above who may not have a severe and persistent mental illness but nevertheless is in acute psychiatric crisis, including suicidal and/or homicidal behavior. Without an immediate mental health intervention, these individuals are at high risk of hospitalization. Such interventions are time limited and not to exceed 120 days. Services include:
(a) Short-term therapy
(b) Medication prescription and monitoring
(c) Referral to community agencies
(d) Designated examinations and dispositions

- **State Hospital Services**

Idaho's two state hospitals are located in Orofino (State Hospital North) and Blackfoot (State Hospital South). State Hospital North is a psychiatric hospital that is licensed for 60 beds. When the building was constructed in 1995 it was designed to have 30 beds to accommodate the acute psychiatric patients and 30 beds to be used for the residential Chemical Dependency Program. The thirty acute beds were located on Quad 3 and the 30 beds for the Chemical Dependency Program were on Quad 4.

During the last several years there has been a steady increase in the number of patients who have been involuntarily committed under Idaho Code 66-329. That increase has created a greater need for psychiatric inpatient beds. In order to try to accommodate those needs the space that was originally designed to house the Chemical Dependency Program (Quad Four) has been used to house and treat the committed patients who have more acute psychiatric problems and require a higher level of care than those that would be in a residential care facility. Because of the increased acuity, it has been necessary to limit the number of patients who are served on Quad Four to 20 in order to assure the safety of the patients and staff on that unit.

With some of the above mentioned changes the focus on programs has also changed. As a part of that, SHN has moved away from being program based and is working more on a service based model. With the change in focus, while SHN no longer has a voluntary residential Chemical Dependency Program, they do still provide substance abuse treatment to approximately 65% of the patients that they serve.

State Hospital South has a total of 90 beds. Acute, intensive, inpatient psychiatric services are provided around the clock to stabilize symptoms of acute mental illness and prepare an individual to return to community-based care.

- **Private Sector Mental Health Services**

The availability of mental health services in the private sector continues to expand in Idaho. With increasing interest in privatization, and increased opportunities to provide Medicaid-reimbursable community mental health services such as targeted case management, clinic option and psychiatric rehabilitation, the private sector continues to grow in size and significance as a provider of services to seriously mentally ill adults.

The following is a list of private inpatient psychiatric treatment facilities and private Medicaid Rehabilitation Option providers in the state.

PRIVATE PSYCHIATRIC INPATIENT FACILITIES BY REGION

REGION	HOSPITAL PSYCHIATRIC UNIT	# of ADULT BEDS	FREESTANDING PSYCHIATRIC HOSPITAL	# of ADULT BEDS
I	North Idaho Behavioral Health Care Center of Kootenai Regional Medical Center	22		
II	St. Joseph Regional Medical Center	20		
III	West Valley Medical Center	12		
IV	St. Alphonsus Hospital	24	Intermountain Hospital SunHealth (primarily substance abuse and geriatric)	40 22
V	Canyon View Psychiatric & Addiction Services of Magic Valley Regional Medical Center – Twin Falls	28		
VI			Portneuf Valley Rehabilitation (Geriatric Unit- 45 and older) Bannock Regional Medical Center	8 15
VII	Eastern Idaho Regional Medical Center- Behavioral Health Center (BHC)	24		

REHABILITATION OPTION PRIVATE SECTOR PROVIDERS
JULY 2003

REGION	APPROVED PRIVATE SECTOR PROVIDERS
I	Advantage Counseling & Rehabilitation Services, Alternative Community Enrichment Services, Inc., Alternative Counseling and Rehab, Area Agency on Aging, Cooperative Care, Inc., Behavior Intervention Services, Cooperative Care Inc., Counseling Services, D&L Associates, Diversified Social Services, Inc., Edwards Community Living Services, Family Support Services of North Idaho, Goodwill Industries, Healthy Resolutions, High Road Human Services, Independence Services, Inc., Moore Support Services, LLC, North Idaho Rehabilitation Support Services, Northwest Behavioral Life Skills, Powder Basin Associates, S. L. Start and Associates, Valley Vista Outreach & Rehab
II	Bentley Counseling and Consulting, Snake River Rehabilitation, Phillips Agency, Inc., Scott Community Care, Susan Call Case Management & Rehabilitation, Weeks & Vietri Counseling, Frontier Journeys, Inc., Clearwater Counseling,, Mountain Lakes Rehab, Independence Services Inc, Malone Counseling, Sequoia Counseling
III	Salud Y Provecho, Boise Valley Counseling, Community Partnerships, All Seasons Mental Health, Human Supports, M.J. Counseling, Affinity Inc., Lifeways Behavioral Health, West Valley Counseling, Alternative

	Counseling, Daybreak Mental Wellness Center, Opportunities Inc., New Directions Counseling Center, Integrity Therapeutic Services, St. Alphonsus Dual Recovery Center, Sufficiency Advocates, Western Idaho Training Co.
IV	Ada Family services, Advocates for Inclusion, Affinity Inc., All Seasons Mental Health, All Together Now, Inc., Alta Counseling and Rehab, Alternative Counseling and Rehab, BHC Intermountain Hospital, Cerebral at Solutions, Community Partnerships of Idaho, Community Support, Inc., Daybreak Mental Wellness Center, Idaho Easter Seals, Franklin House – St. Alphonsus Regional Medical Center, HFC dba Basin Community Health Center, Human Supports of Idaho, Inc., Rehab, Mountain States Group, The ARC, Inc., Sufficiency Advocates, WITCO, Inc.
V	A+ Solutions Center, Alliance Family Services, Community Partnerships of Idaho, Harmony PSR Services, Liberty Care Services, Magic Valley Rehabilitation Services, Pathways, Inc., Positive Connections, Pro Active Advantage, Psychiatric Services, Syringa Support Services, Valley Community Counseling
VI	Academy of Family Services, Access Point Family Services, Aid For Friends, Advocacy & Learning Association, Apex Professional Services, Community Wellness Center, Consumer Care, The Coping Connection, The Children's Center, Family Care Center, Family Pathways Cooperative, Family Services Alliance, Health Works, J & M Mental Health, Joshua D. Smith & Associates, Life Choices, Mental Wellness Center, New Beginnings, Mountain River Mental Health, New Outlook Counseling, Opportunities Inc., PC Mental Health, Reddoor Rehabilitation Services, Rehab Inc., Reliance Mental Health, Road to Recovery, Summit Counseling Services, Teton Family Services, Vista Family Services
VII	Alpine Counseling, Aspen Center Rehabilitation and Counseling, Children's Supportive Services, CLUB, Inc., Counseling Center of Southeast Idaho, Family Care Center, Family Resource Center, Innovative Health Care Concepts, Innovative Health Care Concepts, J&M Mental Health, Inc., Joshua D. Smith and Associates, Lemhi Valley Social Services, Mental Wellness Center, Northfork Developmental Services, Reddoor Rehabilitation Services, Rehabilitative Health Services, Reliance Mental Health Services, Salmon River Industries, The Children's Center, Upper Valley Resource and Counseling Center, Vista Family Services, Youth and Family Renewal Center

5. DESCRIPTION OF HEALTH AND MENTAL HEALTH SERVICES, HOUSING SERVICES, EDUCATIONAL SERVICES AND OTHER SUPPORT SERVICES TO BE PROVIDED TO THE SERIOUSLY MENTALLY ILL.

· **Housing Services**

The Idaho Department of Health and Welfare, Division of Family and Community Services (FACS) contracts with Supportive Housing and Innovative Partnerships, Inc. to provide housing consultation services for FACS personnel, community-based groups, advocacy groups and Community Housing Development Organizations to increase the capacity of all of these organizations to ultimately increase the availability and affordability of housing for persons who have special needs and are served by FACS programs. SHIP, Inc. is a nonprofit organization that was developed by the Boise City Ada County Housing Authority. SHIP provides the following services throughout the state of Idaho:

- Develop, distribute and maintain a Housing Development Guide
- Monitor and disburse information regarding housing funding opportunities
- Acting as a liaison and building collaborative partnerships between the Department and other organizations interested in special needs housing
- Technical Assistance with funding applications
- Providing training and technical assistance

SHIP is also spearheading an effort to develop Oxford Houses throughout Idaho upon request from the Regions. Oxford Houses are group homes for persons who are in recovery from alcohol and/or substance abuse. To date there is one house in Region I, two houses in Region III, five

houses in Region IV, two houses in Region V, one house in Region VI and one house in Region VII. There are additional Oxford houses in development in Regions I, II, III, IV, V and VI. Region II is actively recruiting a willing landlord to develop an Oxford House in the Lewiston area. SHIP also provides technical assistance, notification of funding opportunities, evaluation and feedback of potential proposals for funding for community based groups and advocacy groups working with special needs populations upon request.

Idaho also has a Shelter Plus Care Program which is administered through Idaho Housing and Finance Association. Shelter Plus Care is a rental assistance program for persons who are severely and persistently mentally ill and homeless. The program is in operation in each of the seven regions of the state as a result of HUD's Continuum of Care Awards. Each region has funding for rental assistance for 9 to 11 dwelling units.

Region IV has a Supportive Housing Program called Progressive Alternatives Towards Housing through Support (PATHS) that provides housing and supportive services for homeless persons who are dually diagnosed with their primary diagnoses being a mental illness. This program can serve up to 20 through the housing component. Region VII has a transitional housing program for homeless persons with mental illnesses that is operated by CLUB, a consumer run group.

· **Crisis Response Services and Residential Facilities**

All regions recognize the importance of crisis residential facilities to support community crisis intervention and offer alternatives to hospitalization. Provision of crisis residential services allows for consumers to often avoid costly and lengthy inpatient stays while affording continuity of care with local treatment providers. The regional CMHC's continue to utilize a variety of hospital diversion strategies including crisis companions, crisis respite beds in residential substance abuse treatment centers, and integrated crisis assessment teams with staff trained to respond to persons with co-occurring disorders (mental health/substance abuse). The following is a description of activities and strategies employed by each region to provide crisis stabilization resources in the local community.

Region I Adult Mental Health has a 3 bedroom respite house which includes accommodations for a live in respite manager. The manager is required to be at the house from 10:00pm to 8:00 am and provides assistance with problem solving, transportation and linkage to community resources. The manager is a paraprofessional who has some training in human services and experience working with consumers who have a mental illness. All clients must have a major mental illness with at least 2 functional limitations. They cannot be a danger to self or others, and must be having a sub acute psychiatric crisis in which there would be a risk of hospitalization if respite intervention was not available. In order to be admitted to the house, clients must be screened and approved by the crisis response team, and must agree to and be willing to work on a plan to resolve their crisis. They must also agree to conform to the respite house rules. The length of stay is a maximum of 7 days. From July 1, 2002 to June 30, 2003 we provided respite services for 48 people

Region II has one "safe bed" at Gritman Hospital which can be used for crisis and a safe place while waiting for a placement at State Hospital North. There is also a bed available in Orofino at

a nursing home to hold clients until they can be placed at State Hospital North. These beds are not considered crisis diversion placements as they are intended to provide temporary safe holding placements until a state hospital admission is available.

Region III has secured one crisis bed in Nampa. The bed is affiliated with the Touchstone consumer drop in center which is governed by a consumer board. Access to the crisis bed is arranged through the CMHC crisis team. The bed is fund by the regional CMHC program budget. Crisis support services are provided by the CMHC clinicians and contracted psychiatrist and can be delivered for up to 120 days.

Region IV has an 8 bed 24 hour crisis residential facility known as Franklin House, previously described, which opened in October of 1998.

Region V has arranged for a crisis bed at Woodstone Retirement Center.

Region VI has contracted with Road to Recovery for three crisis beds. The beds are available for individuals who are experiencing acute psychiatric crisis but are not in need of inpatient treatment. These are voluntary placements and are intended to be for short term stays only. The contract provides for 24 hour supervision, medication distribution, food and shelter.

Region VII has developed a number of community resources for the provision of crisis beds. The CMHC has agreements with the ARA substance abuse facility for the use of one male crisis bed and one female crisis bed and agreements with three residential and assisted living facilities for crisis beds. The program also pays for one home with four crisis beds for men and one home with four crisis beds for women. The regional CMHC also utilizes crisis housing available through CLUB Inc. which includes four men's crisis beds, six transitional beds for men, four crisis beds for women, four transitional beds for women and one transitional bed for either a male or female. They also regularly access the services of the Haven Homeless Shelter for women and children and the City if Refuge for Homeless Men.

· **Lodge/Semi-Independent homes**

The following lodge/semi-independent homes are available to the seriously mentally ill in Idaho. Additionally, supportive housing options such as Residential and Assisted Living Facilities and Certified Family Homes are available throughout the state.

STATEWIDE LODGE/SEMI-INDEPENDENT HOMES

REGION	LODGE	CAPACITY
I	Trinity Group Homes 1601 Gilbert Ave., Coeur d' Alene, ID 83814	 12
II	Latah Alliance for the Mentally Ill, 123 N Lillie, Moscow, ID 83843	6
III	Touchstone Starlight House, 3421 Starlight, Caldwell ID 83605 (Semi-independent) St. Germaine, 903 E Amity, Nampa ID 43686 (Semi-independent)	5 5

IV	The Lodge, 3102 N 32nd, Boise ID 83701 The Lodge II, 3004 Taft St, Boise ID 83703	6 7
V	Cosmopolitan Lodge, 1708 Poplar, Twin Falls ID 83301 CSC Independence Lodge, 2110 Yale, Burley ID 83318	8 5
VI	Raymond House, 723 E Lander, Pocatello ID 83201	8
VII	None	

· **Vocational and Educational Services**

In addition to services provided statewide by the Division of Vocational Rehabilitation located in local communities, Idaho has developed a unique program of assigning vocational rehabilitation counselors to regional CMHC assertive community treatment teams (ACT). These counselors provide vocational services to ACT clients as well as other clients of the mental health program. Services include work skills assessments, career counseling, rehabilitation plan development, and referrals to vocational and educational services such as job coaching, transportation, job shadowing, adult education and literacy services (GED and college level courses), and transitional/sheltered work experiences.

Idaho also distributes state community supportive employment (CSE) funds to regional CMHC's each July. As individual vocational rehabilitation plans are developed, funds are placed in individual accounts allowing consumers maximum choice of vocational service providers and flexibility in the budgeting/spending of these monies.

· **Consumer Operated Drop-in Centers, Consumer Club House Model Facilities and Consumer and Family Member Self-Help Groups**

The following tables list by region the names of consumer and family member self-help groups, consumer drop-in centers and clubhouses available in the state of Idaho. It must be noted, however, that each regional CMHC also has an advisory board that participates directly in regional mental health policy and decision making. Consumers and family members from all 7 regions also serve on the Idaho State Planning Council on Mental Health. The Office of Consumer Affairs and Technical Assistance regularly provides technical assistance and support to the consumer groups and is actively engaged in developing consumer support programs.

STATEWIDE CONSUMER DROP-IN CENTERS AND CLUBHOUSES

REGION	DROP-IN CENTERS	CLUB HOUSES
I	CSC Bonners Ferry Gardenia Club Consumer Connection Rainbow Club	
II		
III	Touchstone	

IV		Recovery Treehouse
V	Harmony Club CSC Burley CSC Twin Falls	
VI	Activity Center	
VII	CLUB, Inc.	

STATEWIDE CONSUMER AND FAMILY MEMBER SELF-HELP GROUPS

REGION	CONSUMER GROUPS	FAMILY MEMBER GROUPS
I	Idaho Consumer Advocacy Network (Umbrella organization for four separate groups) Consumer Connection	NAMI of Coeur d' Alene NAMI of Benawah NAMI Silver Valley
II	Confluence Club	NAMI of Latah County NAMI of Lewis/Clark Valley
III	Touchstone Schizophrenics Anonymous Mental Health Association of Idaho	NAMI of Quad Counties NAMI of Canyon County
IV	Schizophrenics Anonymous	NAMI of Boise NAMI of McCall
V	Community Support Center, Inc. Twin Falls and Burley Harmony Club	NAMI of Mini-Cassia NAMI of Magic Valley NAMI of Wood River Valley
VI	People of Pocatello Consumer Works Inc. Peer Companion Group Consumer Advocates of Pocatello	NAMI of Southeast Idaho
VII	CLUB Inc. COMFORT Tri-County Manic Depressive Support Group	NAMI of Upper Valley, Idaho Falls
Statewide	Mental Health Association of Idaho Idaho Office of Consumer Affairs and Technical Assistance Idaho Leadership Academy	NAMI, Idaho Chapter, Albion Family to Family- NAMI sponsored Red Flags Idaho

· **Medical and Dental Services**

Medical and dental needs for consumers in the public mental health system are identified during the assessment process. The assessment is used to address the individual's medical history and current health problems and identify needs. Medical/Health is an area that can be included in the PSR service plan to assist a consumer with learning to access needed medical and dental

services and develop skills to better manage their medical needs. Case management services provide assistance with coordination of and referrals to community medical and dental providers.

Access to medical and dental services for those without private insurance or Medicaid benefits is limited across the state. There are some community providers such as the Terry Reilly Health Clinics that provide medical and dental services on a sliding fee scale in limited areas. Idaho also has a very limited county indigent program that varies by county with what services are covered. The program is usually limited to one-time expenses. Medical and dental services for those without insurance or Medicaid are not consistently available in all areas of the state.

The Idaho Medicaid program encourages recipients to sign up for Healthy Connections. Healthy Connections is Medicaid's managed care program. It provides a medical home for Medicaid clients by having one doctor responsible for the client's entire health care, referring a client to a specialist when necessary. The doctor gets an extra fee for each Healthy Connections patient he serves. The Department gets better care management and lower costs.

Publicly funded Medicaid reimbursable medical services available to adults with a serious and persistent mental illness include:

Ambulance Service
Developmental Disability Services
EPSTD Health Check
Family Planning Services
Hospice Care
Prescription Medications
Nursing Home Services
Podiatry
Prosthetic and Orthotic Services
Ambulatory Surgical Services
Occupational Therapy
Speech and Hearing Therapy
Traumatic Brain Injury Services
Dental Services
Chiropractic Services
Physician Services
Medical Equipment and Supplies
Home Health Services
Hospitalization
Mental Health Services
Personal Assistance Care
Pregnancy Related Services
Respiratory Care Services
Developmental Therapy
Physical Therapy
Transportation Services
Vaccinations

In an attempt to slow the growth of Medicaid costs several changes to Medicaid benefits were made during the 2003 Legislative session. In FY 02, Dental services for adult Medicaid clients were limited to emergency services only. The 2003 Legislature restored $750,000 in general fund money to provide more dental services to Medicaid adults. With the federal match, the total additional money available is almost $2.6 million. The "restoration" means Medicaid adults will have access to exams and cleanings, x-rays, stainless steel crowns, scaling, simple or basic fillings, preventative treatment for high risk patients (those with chronic diseases like diabetes), extractions, partial or full dentures and pulpectomy. Procedures restored to adult dental are those that will relieve pain not cosmetic. The newly restored procedures will take effect on July 1, 2003.

Idaho Medicaid is also in the process of implementing a new prior authorization process for medication prescription benefits. The new Enhanced Prior Authorization Program is an

evidenced based, technologically improved program for prior authorizing classes of medications. The program consists of two new features:

1. An automated system to receive and review PA request to speed service and promote convenience to the pharmacy, prescriber and patient.
2. A new procedure for reviewing classes of medications to aid in determining prior authorization guidelines.

The program will utilize evidence based data to develop criteria that will aid in the decision to choose the most appropriate medication for the client. The enhanced prior authorization program will enable the prior authorization of more medications within a therapeutic class. Recommendation on prior authorization guidelines will come from a Pharmacy and Therapeutics (P&T) Committee made up of Idaho physicians, pharmacist and other healthcare professionals. The Enhanced Prior Authorization Program is planned to go into effect in December 2003.

Service limits were also implemented in Targeted Case Management, which previously had no service limitations. A limit of 5 hours for ongoing case management services and 3 hours for emergency case management service was implemented. A procedure was developed for prior authorizing any additional service hour requests beyond the established limits.

Idaho also has seven public health districts that are the primary outlets for public health services. These districts work in close cooperation with the Department of Health and Welfare and numerous other state and local agencies. Each district has a board of health appointed by the county commissioners within that region. The districts are not part of any state agency. Each district responds to local needs to provide an array of services that may vary from district to district. Services range from community health nursing and home health nursing to environmental health, dental hygiene and nutrition programs. Many services are provided through contracts with the Department of Health and Welfare.

6. ACTIVITIES TO REDUCE THE RATE OF HOSPITALIZATION OF THE SERIOUSLY MENTALLY ILL.

The state of Idaho is committed to activities designed to increase the effectiveness of community-based services, while at the same time seeking opportunities to reduce the rate of hospitalization of adults with serious mental illness.

In Idaho, a variety of strategies are in use (and receive the strong support of both the regional community mental health programs and the state hospitals) as multiple ways to reduce the rate of hospitalization of adults with serious mental illness

a. An increased emphasis on **communication and cooperation** between the state hospitals and the community mental health programs in order to make timely decisions about admissions and discharges, identify at an early stage potential barriers to timely discharge, and promote the sense of teamwork between hospital and community staff and administrators.

b. An increased emphasis on **effective community crisis response,** so as to avoid inappropriate or unnecessary hospitalization. It is well documented in the literature that a key factor in reducing hospitalization rates is the presence of effective, 24-hour community crisis response teams to be able to intervene and appropriately divert from hospitalization. Too often hospitalization is the first choice, whereas in a competent system of community crisis response it becomes the choice of last resort.

c. An increased emphasis on the development of **alternative residential programs** in or close to the client's home community, including crisis and respite beds and "24 hour" residential programs. Franklin House is one example of such programs.

d. An increased maturity of practice and advanced competence on the part of the regional Assertive Community Treatment teams, resulting in a **greater ability to maintain seriously mentally ill in the community.**

e. The Adult Mental Health program continues to prioritize reducing the number of state psychiatric hospitalizations and decreasing the length of stay. Several initiatives are underway to facilitate improved "**diversion"** strategies in decreasing the utilization of the state psychiatric hospital system. Idaho continues to experience waiting lists for involuntary admissions to the two state hospitals. In an effort to develop additional community based alternatives to inpatient treatment, specific initiatives are being targeted to develop strategies for community based alternative placements. These include the development of Transition Bed plans and outcome measures, protocols for handling criminal commitments and policy development for coordination of services with Drug Courts.

7. AVAILABILITY OF CASE MANAGEMENT SERVICES TO EACH ADULT MENTAL HEALTH CONSUMER IN THE STATE WHO RECEIVES SUBSTANTIAL AMOUNTS OF PUBLIC FUNDS OR SERVICES.

Perhaps the most important first step under discussion of this criterion is to define "case management." For the purposes of this plan, case management is defined as "the single (and therefore ultimate) point of responsibility for any given open case."

Using this definition, it may be said that in Idaho case management is provided to all individuals who meet the priority population definition and who are receiving substantial amounts of public funds or services. In practice, the **intensity** of case management provided varies from individual to individual, as needed and appropriate. In this sense, there is a continuum of case management services which is available to each individual. This continuum varies in intensity from the most intense activities under Assertive Community Treatment and Community crisis response; services under Psychosocial Rehabilitation and Targeted Case Management funded by Medicaid; and, for example, less intense case management for those needing medication management.

8. SERVICES TO PERSONS WHO ARE DUALLY DIAGNOSED (CO-OCCURING MENTAL ILLNESS AND SUBSTANCE ABUSE)

During this past year there have been greater efforts placed on coordination between the regional CMHC's and Drug Courts. More detailed information on services for persons who are dually diagnosed being offered by the regional programs is as follows:

REGION I- Currently the substance abuse treatment needs of the dually diagnosed are primarily being referred to treatment facilities outside of the CMHC. The Crisis Response Team (CRT) performs a mental health screening at the CMHC and if a dually diagnosed client is identified an appropriate referral will be made to better meet the needs of the individual. Consumers screened who have a documented mental illness or prior mental health symptoms that preceded their substance abuse will be opened for CMHC services. Referrals are made to outside agencies to meet the substance abuse treatment needs. Referrals are usually made to North Idaho Behavioral Health, Port of Hope and Powder Basin. However, there often are waiting lists for clients to be seen, or they do not have insurance or the funds to pay for treatment. It has become increasingly important for the CRT to make referrals for the client to access support services such as AA or similar support groups. The CMHC has a support group for the dually diagnosed. This group meets once a week at KMC for one hour and averages about five people.

Three counties in the region have drug courts. The Court has contracted with Powder Basin Associates to provide assessments, treatment planning and treatment services. Referrals are made to the regional CMHC as needed.

REGION II- The Region II Mental Health Center has one clinician who is a certified substance abuse counselor assigned as a lead clinician for dual diagnosis-substance abuse issues. All mental health staff work conjointly with the Substance Abuse Contract agency in order to coordinate and optimize services for consumers who are receiving both mental health and substance abuse services.

Regional CMHC staff attend the monthly drug court coordinating team meetings. There is an identified liaison who consults with the court as needed. The CMHC also provided consultation services to the drug court counselors pertaining to mental health issues and provides screening services for any referrals received the from the court. There are currently four drug courts in the District.

REGION III- Region III Community Mental Health Center works closely with several entities to improve the accessibility of treatment for adults with severe, chronic mental illness. Bell Counseling, an established substance abuse treatment program in the region, provides a long-term residential treatment program for women. The Regional CMHC has also worked with the Port of Hope to assist clients in accessing detox, inpatient, and outpatient services for substance abuse issues. Region III Mental Health is an active participant in the Regional Substance Abuse Authority monthly meeting. This group is comprised of representatives from all of the local substance abuse treatment programs, school teachers, recovering community members, housing providers, school board members, police, and probation officers. They meet monthly to prioritize the use of substance abuse dollars for the entire region and complete Requests for

Proposals. By emphasizing the need for treatment resources for adults with Co-Occurring disorders, they have been able to improve the availability/accessibility of local treatment programs. Drug court has expanded in Canyon County and has improved integration with the CMHC. Participants in the Drug Court program are expected to work with a Drug Court Coordinator to develop an intensive treatment program to address substance abuse issues. Private providers in the local community provide treatment. The length of the treatment program is at least one year. Successful completion of Drug Court entails successful completion of all recommended treatment programs (SA Treatment, mental health treatment, anger management classes, parenting classes, educational, vocational, etc). The regional CMHC also offers a co-occurring disorders treatment group with 6-8 regular attendees.

Regional CMHC staff attends the weekly staff meeting with the core team of the Canyon County drug court. All consumers identified where a mental health condition exists are referred for screening, assessment and coordination services at the CMHC office. Consumers are seen within 24 hours of the referral. Ongoing consultation and staffing is provided throughout the course of the drug court series.

REGION IV- Region IV Mental Health Center has one Road To Recovery liaison staff assigned to the Mobile Crisis Unit who is a Certified Addiction Counselor (CADC). This staff person performs alcohol and substance abuse assessments and crisis response services to the dually diagnosed. The Regional Mental Health program refers consumers to community based substance abuse treatment providers including Road to Recovery, St. Alphonsus Addiction Recovery Center, City of Boise/Road to Recovery Methamphetamine Outpatient Clinic and Port of Hope.

The regional CMHC has an identified a point of contact for the drug court. The CMHC program receives referrals, provides consultation and conducts mental health screening services when indicated.

REGION V- Region V Mental Health Center provides a weekly Dual Diagnosis support Group in two locations, Twin Falls and Rupert. The Minkoff model is the theoretical foundation for both groups. Due to the diversity of the groups the program has been eclectic in its approach. The programs have a 12-step basis and are open ended, supportive/therapeutic, didactic and educational. Reality therapy is a very strong component to each and every group. The Rupert group has a mix of consumers that include those in pre-engagement phase through relapse prevention. The Twin Falls group includes consumers in early active treatment to relapse prevention. The programs are beginning to include involved family members. In addition, the regional program provides evaluation and referrals to community based substance abuse providers, follow-up treatment for dually diagnosed consumers discharged from the state hospitals and participates actively with the local Drug Court and the RSAA. A cooperative agreement between the regional mental health program and the Walker Center for evaluations and treatment by both parties has also been established. The CMHC has also sponsored local education efforts on substance abuse issues with nationally recognized experts and is the cosponsor for the two Oxford houses in the Region. The CMHC also provides staff member representation on the screening committee for participation in the Oxford House option.

The regional CMHC has one staff person assigned to spend two hours weekly attending the Drug Court and conducting pre-screenings and consultations to the court on mental health issues. A complete screening is conducted to anyone referred to the CMHC from the drug court for assessing eligibility and developing individual treatment plans.

REGION VI- Region VI Mental Health Center sponsors a Dual Diagnosis group focusing on those with a severe and persistent mental illness and substance abuse. The group meets one time per week for an hour and a half. Regular attendance has been 5-7 consumers weekly. The group is conducted by licensed clinicians. Elements of the Bio-psycho-social recovery model with the 12-step model are the foundation for the group. They also incorporate motivational enhancements theory. The group is identified as having a good attendance rate. A weekly community dual diagnosis group is also offered in Blackfoot.

Regional CMHC staff is assigned to attend weekly staffing and to provide consultation, screening and referral services to the Drug Court committee. Consultation is also provided in determining if an individual would benefit from participation in the Drug Court. The program also continues to work with Road to Recovery staff to divert individuals before they come into contact with the legal system.

REGION VII - Region VII Mental Health Center offers two Dual Diagnosis groups each week for CMHC consumers. The groups are facilitated by the ACT team clinicians. The Regional Substance Abuse Authority has also contracted for services with a community provider for the provision of services for persons with a dual diagnosis. Additionally, three CMHC staff are assigned to attend five Drug Court weekly staffings. The CMHC staff provides screening and assessment services as referred by the court.

B. GOALS AND OBJECTIVES

GOAL 1: TO IMPROVE ACCESS, QUALITY AND APPROPRIATENESS OF SERVICES TO THE TARGET POPULATION, AND DEMONSTRATE IMPROVED QUALITY OF LIFE AND POSITIVE OUTCOMES FOR THE TARGET POPULATION.

Objective 1.1 Implement a new process for conducting MHSIP Satisfaction Surveys for consumers receiving DHW provided CMHC services by the end of FY04.

Population	Adults receiving ongoing DHW mental health services
Criterion	To improve access, quality and appropriateness of services
Brief Name	Consumer reported satisfaction with mental health services
Indicators	Percentage of consumers receiving DHW publicly provided services who rate positive satisfaction with services
Measure	
Numerator	Number of consumers who rate positive satisfaction with services
Denominator	Number of completed consumer satisfaction surveys
Sources of Information	IMHP, MHSIP Consumer Survey, CAMIS, Visual Basic

	Rehabilitation Outcomes Database (VBROD)
Special Issues	FACS is in the process of developing a new data tracking system to meet the new MHSIP requirements. As a result of this transition, the previous data tacking systems will no longer be compatible with the new system and all previously collected data is no longer comparable to new data. New baseline measures for all performance indicators will need to be established during this FY. The Adult Mental Health Program will be implementing the MHSIP Consumer Survey and will develop a process for using the NRI online consumer survey data base.
Significance	Measurement of consumer satisfaction is an important component in assessing the overall quality and appropriateness of services. This supports the Planning Council's priorities related to Quality.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1.Consumer reported satisfaction with services				
Value				
If rate: **Numerator:** Number of consumers who rate positive satisfaction with services **Denominator:** Number of completed satisfaction surveys.	**No comparison data available**			

<u>Objective 1.2</u> Achieve a 5% competitive employment rate for consumers receiving DHW provided mental health services.

Population	Adults in Idaho receiving DHW provided mental health services
Criterion	To improve access, quality and appropriateness of services
Brief Name	Competitive employment
Indicators	Percentage of consumers receiving DHW publicly provided services who report competitive employment (includes supported employment) during FY04
Measure	
Numerator	Number of consumers receiving DHW services who report competitive employment (includes supported employment) during FY04
Denominator	Number of SPMI adult receiving DHW services in Idaho
Sources of Information	IMHP, CAMIS, VBROD

Special Issues	FACS is in the process of developing a new data tracking system to meet the MHSIP requirements. As a result of this transition, the previous data tacking systems will no longer be compatible with the new system and all previously collected data will no longer be comparable. New baseline measures for all performance indicators will need to be established during this FY.
Significance	Achieving competitive employment has been shown to be one of the key indicators of the recovery process for persons with SPMI. This objective supports the Planning Council's objective on continuum of care and community supports.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 2. Competitive employment				
Value			5%	
If rate: **Numerator:** Number of consumers receiving DHW MH services who report competitive employment **Denominator:** Number of consumers receiving DHW MH services in Idaho	**No comparison data available**			

<u>Objective 1.3</u> Establish a baseline rate for consumers receiving DHW provided mental health services who report independent housing during FY04.

Population	Consumers receiving DHW provided mental health services
Criterion	To improve access, quality and appropriateness of services
Brief Name	Assisted/supportive housing
Indicators	Percentage of consumers receiving DHW MH services who report independent living during FY04
Measure	
Numerator	Number of consumers receiving DHW mental health services who report an independent living arrangement during FY04
Denominator	Number of consumers receiving DHW mental health services in Idaho
Sources of Information	IMHP, CAMIS, VBROD
Special Issues	FACS is in the process of developing a new data tracking system to meet the MHSIP requirements. As a result of this transition, the previous data tracking systems will no longer be compatible with the new system and all previously collected data will no longer be comparable. New baseline measures for all performance indicators will need to be established during this FY.
Significance	Achieving and maintaining independent housing is an important

	indicator of the recovery process for persons with SPMI. This objective supports the Planning Council's objective on continuum of care and community supports.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 3. Independent housing				
Value				
If rate: **Numerator:** Number of consumers receiving DHW mental health services who report independent housing during FY04 **Denominator:** Number of consumers receiving DHW MH services in Idaho	**No comparison data available**			

Objective 1.4 Establish a baseline rate for consumers receiving DHW provided mental health services who report receiving supportive residential services during FY04.

Population	Consumers receiving DHW provided mental health services
Criterion	To improve access, quality and appropriateness of services
Brief Name	Supportive residential services
Indicators	Percentage of consumers receiving DHW MH services who report supportive residential services during FY04
Measure	
Numerator	Number of consumers receiving DHW mental health services who report supportive residential services during FY04
Denominator	Number of consumers receiving DHW mental health services in Idaho
Sources of Information	IMHP, CAMIS, VBROD
Special Issues	FACS is in the process of developing a new data tracking system to meet the MHSIP requirements. As a result of this transition, the previous data tracking systems will no longer be compatible with the new system and all previously collected data will no longer be comparable. New baseline measures for all performance indicators will need to be established during this FY.
Significance	Achieving and maintaining independent and supportive housing is an important indicator of the recovery process and a desired outcome over institutional housing for persons with SPMI. This objective supports the Planning Council's objective on continuum of care and community supports.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 4. Supportive housing				
Value				
If rate: **Numerator:** Number of consumers receiving DHW mental health services who report supportive residential services during FY04 **Denominator:** Number of consumers receiving DHW MH services in Idaho	**No comparison data available**			

<u>Objective 1.5</u> Maintain the previous fiscal years level the % of persons seen for a first face to face appointment at their community mental health provider within 7 days of discharge from a state hospital in Idaho.

Population	Persons discharged from state hospitals
Criterion	To improve access, quality and appropriateness of services
Brief Name	Community follow-up after state hospital discharge
Indicators	Percentage of persons seen at their community mental health provider within seven days of discharge from a state hospital in Idaho
Measure	
Numerator	Number of persons in FY04 seen by community provider within seven days of discharge from state hospital
Denominator	Number of persons discharge from state hospital
Sources of Information	State hospital database
Special Issues	This objective supports the Planning Council's objective on, quality, continuum of care and community supports.
Significance	Timely follow-up in the community is a significant indicator for successful community integration and for reducing the rate of re-hospitalization.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 5. Community follow-up after state hospital discharge				

Value	64.7%	64.7%	64.7%	
If rate: **Numerator:** Number of persons seen by community provider within seven days of discharge from state hospital **Denominator:** Number of persons discharge from state hospital				

Objective 1.6 Maintain at the previous fiscal years level the % of persons discharged from a state hospital in Idaho who are admitted for inpatient psychiatric care within 30 days.

Population	Adults returning to the community following state hospital discharge
Criterion	To improve access, quality and appropriateness
Brief Name	Readmission rates following state hospital discharge
Indicators	Percentage of persons who are admitted for psychiatric inpatient treatment within thirty days of state hospital discharge
Measure	
Numerator	Number of persons readmitted within thirty days of state hospital discharge in FY04
Denominator	Number of persons discharged from a state hospital
Sources of Information	State hospital database
Special Issues	This objective supports the Planning Council's objective on quality, continuum of care and community supports.
Significance	Maintenance in the community following state hospital discharge is an important indicator of quality on the part of the community mental health service providers and the quality of the state hospital discharge process.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 6. Readmission rates following state hospital discharge				
Value	5.6.%	5.6.%	5.6.%	
If rate: **Numerator:** Number of persons readmitted within thirty days of state hospital discharge in FY04 **Denominator:** Number of persons discharged from a state hospital				

Objective 1.7 **Maintain at the previous fiscal year's level the % of persons discharged from a state hospital in Idaho who keep their first medication follow-up appointment with a physician or physician extender at their community mental health provider.**

Population	Adults discharged from a state hospital in Idaho
Criterion	To improve access, quality and appropriateness of services
Brief Name	Community follow-up with physician
Indicators	Percentage of persons discharged from a state hospital who keep their first medication follow-up appointment with a physician or physician extender at their community mental health provider
Measure	
Numerator	Number of persons in FY04 who keep their first medication follow-up appointment with a physician
Denominator	Number of persons discharged from a state hospital
Sources of Information	State hospital databases
Special Issues	This objective supports the Planning Council's objective on quality, continuum of care and community supports.
Significance	Keeping their first medication follow-up appointment in the community is a key indicator of successful community reintegration and treatment compliance.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 7. Community follow-up with physician				
Value	73.9%	73.9%	73.9%	
If rate: **Numerator:** Number of persons in FY04 who keep their first medication follow-up appointment with a physician **Denominator:** Number of persons discharged from a state hospital				

Objective 1.8 **Develop a statewide Transition Bed plan and outcome measures to facilitate diversion from the state hospital system during FY2004.**

Population	Providers of public mental health services
Criterion	To improve access, quality and appropriateness of services
Brief Name	Transition Bed plan and outcome measures
Indicators	Write and adopt a statewide transition bed plan
Measure	
Numerator	
Denominator	
Sources of Information	
Special Issues	The State continues to experience increasing population, limited resources and increasing pressure on state funded inpatient services. The need to develop innovative alternatives to inpatient treatment and assure access to appropriate community based care remains a high priority.
Significance	This objective corresponds to the State Planning Council's Adult Mental Health priorities of recognizing outcome measures as persuasive data, equitable access to care and to define and further develop an array of mental health services.

Objective 1.9 **Finalize and adopt a statewide plan and policies for coordination of services between the CMHC's and the Drug Courts during FY2004.**

Population	Providers of public mental health services and the Drug Courts
Criterion	To improve access, quality and appropriateness of services
Brief Name	Drug Court plan

Indicators	Finalize and adopt a statewide plan and policies for CMHC's and drug courts
Measure	
Numerator	
Denominator	
Sources of Information	
Special Issues	The mental health system has been impacted with the implementation of Drug Courts resulting in an increased demand for coordination, consultation, assessment and treatment services. A formalized agreement between the Courts and the Adult Mental Health program will facilitate continuity of care and maximize opportunities for diversion to treatment.
Significance	This objective corresponds to the State Planning Council's Adult Mental Health priorities to develop professional competencies and standards, equitable access to care and to define and further develop an array of mental health services.

Objective 1.10 Identify and adopt outcome measures and performance standards for Community Supported Employment providers during FY2004.

Population	CSE providers, consumers and providers of public mental health services,
Criterion	To improve access, quality and appropriateness of services
Brief Name	Community supported employment standards
Indicators	Identify and adopt CSE outcome measures and performance standards
Measure	
Numerator	
Denominator	
Sources of Information	
Special Issues	To improve the quality and accountability for employment services received by Idaho consumers.
Significance	This objective corresponds to the State Planning Council's priorities of recognizing outcome measures as persuasive data and to develop professional competencies and standards.

CRITERION 2

ESTIMATES OF PREVALENCE AND TREATED PREVALENCE OF MENTAL ILLNESS: The plan contains estimates of the incidence and prevalence in the state of SMI and SED and contains quantitative targets to be achieved in the implementation of the mental health system, including the numbers of individuals with SMI and SED to be served.

A. NARRATIVE

1. ESTIMATES OF NEED AND SERVICE PENETRATION IN IDAHO.

The following tables include a quantitative target of the number of adults with serious mental illness in Idaho expected to be served by Idaho's Public Mental Health System in FY2004, as well as actual numbers served in FY2003. In reviewing these tables, please remember that (a) These numbers represent Idaho's best estimate to date of incidence, treated prevalence, and quantitative targets. (b) These numbers represent publicly provided and funded (including Medicaid) mental health services rendered by the public sector. (c) Some individuals received services from both public mental health system and private sector providers during FY2003. (d) In Idaho, due to funding constraints, the target population is *serious and persistent mental illness*, a narrower subset of serious mental illness.

ADULT MENTAL HEALTH FY2003 (ACTUAL)

SERVICE TYPE	PUBLIC
ACT Teams	392
Psychiatric Rehabilitation	2,934
Targeted Case Management	595
Outpatient Clinic Services	100
Other MH Services (Medication Only, Crisis Response, etc., non-billable)	7,961
Total Persons Served	**11,982**

PROJECTED TO BE SERVED FY2004

SERVICE TYPE	PUBLIC
ACT Teams	392
Psychiatric Rehabilitation	2,934
Targeted Case Management	595
Outpatient Clinic Services	100
Other MH Services (Medication Only, Crisis Response, etc.)	7,961
Total Persons Served To Be Served	11,982

PROJECTED ADULT/SPMI POPULATIONS, BY REGION

	Regions							
	I	II	III	IV	V	VI	VII	TOTAL
2000 Adult Population	130,928	77,680	133,101	250,556	114,778	105,645	112,235	924,923
Estimated Adult SMI Population (5.4%)	7,070	4,195	7,187	13,530	6,198	5,705	6,061	49,946
Estimated Adult SPMI Population (2.6%)	3,404	2,020	3,461	6,514	2,984	2,747	2,918	24,048

2. METHODOLOGY FOR ESTIMATE OF INCIDENCE AND PREVALENCE

The state of Idaho uses the estimation methodology for adults required by the Substance Abuse Service Administration's Center for Mental Health Services (CMHS). This methodology was last promulgated in the *Federal Register* dated June 24, 1999, and derives its data from the National Co morbidity Survey (NCS) and the Epidemiological Catchment Area (ECA) studies of the National Institute for Mental Health.

The 2000 Idaho total population estimate of age 18 and over from the U.S. Bureau of Census is 924,923.

Based on this estimate of the adult population and current CMHS estimation methodology establishing prevalence at 5.4%, it may be concluded that there are 49,946 adults in the state of Idaho with serious mental illness. Using this same methodology and the prevalence rate of 2.6%, it may be concluded that there are 24,048 adults in the state of Idaho with serious and persistent mental illness.

B. GOALS AND OBJECTIVES

GOAL 2: TO INCREASE THE NUMBERS OF PERSONS BEING SERVED BY THE STATE'S PUBLIC MENTAL HEALTH SYSTEM

Objective 2.1 Provide public funded mental health services to a minimum of 11,982 persons during FY04.

Population	Persons in Idaho being served by the public mental health system
Criterion	Estimates of prevalence and treated prevalence of mental illness
Brief Name	Service penetration
Indicators	Number of adults in Idaho being served by the public funded mental health system
Measure	Total number of adults served by the public funded mental health system
Numerator	
Denominator	
Sources of Information	DAR, IMHP, CMIS
Special Issues	It should be noted that the 2003 projected number of 11,982 represents the enhanced ability to collect data for non billable client's served by DHW. The 2002 DHW client counts reflect an updated count for non billable clients served as the 2002 non billable client count numbers reported in the FY 03 plan were for a partial year only. This reporting capability was not previously available. 2003 data will be the first full year for reporting improved client counts.
Significance	Given the influences of population growth, no significant growth in state funding and major system redesign projected for FY04, it

	is likely that at best we will only maintain at the same level of the previous year the number of persons we serve in FY04. This objective supports the Planning Council's priorities related to equitable access to care.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. DHW service penetration				
Value	9,898	11,982	11,982	
If rate: **Numerator:** **Denominator:**				

<u>Objective 2.2</u> Establish a baseline count for the numbers of Hispanic/Latino and American Indian consumers accessing Adult CMHC services in the state during FY04.

Population	Adults of Latino/Hispanic heritage and American Indians with receiving DHW Mental Health services
Criterion	To improve access, quality & appropriateness of services
Brief Name	Hispanic/Latino and American Indian access to services
Indicators	The number of Latino/Hispanic and American Indian consumers receiving services
Measure	Number of Latino/Hispanic and American Indian consumers receiving services in FY04
Numerator	
Denominator	
Sources of Information	DHW databases (DAR, IMHP, CMIS)
Special Issues	This is a variable the state has not previously had the capacity to track. A baseline will be established during this FY for use in future year's planning and system evaluation to evaluate and ensure equal access to services for minority populations.
Significance	Outreach to minority populations and equitable access to minority populations remains an important issue, both nationally and as a way of demonstrating Idaho's commitment to serve minority populations. This objective supports the Planning Council's priorities on equitable access to care.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 2. Latino access to services				
Value - Number of Latino/Hispanic consumers receiving services in FY04 Number of American Indians receiving services in FY04.	N/A N/A			
Numerator: **Denominator:**				

Objective 2.3 The Division of Family and Children's Services will begin collecting all required MHSIP data elements beginning October 1, 2003.

Population	Persons in Idaho being served by the public mental health system
Criterion	Estimates of prevalence and treated prevalence of mental illness
Brief Name	Data collection
Indicators	The implementation of data collection for required MHSIP data.
Measure	
Numerator	
Denominator	
Sources of Information	IMHP, CAMIS, DAR
Special Issues	Idaho was awarded a Data Infrastructure Grant and is in the process of developing and implementing a single data tracking system to meet the Federal MHSIP requirements for mental health services.
Significance	This objective supports the State Planning Council's priorities on funding data gathering and analysis systems.

CRITERION 3

INTEGRATED CHILDREN'S SERVICES PROVISION: The plan provides a comprehensive system of integrated community mental health services appropriate for the multiple needs of children.

(NOT APPLICABLE TO ADULT PROGRAM)

CRITERION 4

TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS: The plan provides for the establishment and implementation of a program of outreach to and services for individuals with SMI or SED who are homeless; and additionally describes the manner in which mental health services will be provided to individuals residing in rural areas.

A. NARRATIVE

1. ESTABLISHMENT AND IMPLEMENTATION OF OUTREACH TO, AND SERVICES FOR, SUCH INDIVIDUALS WHO ARE HOMELESS.

Outreach to, and services for, homeless individuals with serious mental illness are provided in Idaho under the auspices of the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program of the Center for Mental Health Services. Idaho has participated in this federal grant program for the past eight years and anticipates Project funding for FY 2004.

The homeless population comprises those individuals who have a serious mental disorder diagnosable under DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994), which includes: schizophrenia, schizoaffective disorder, major affective disorder, delusional disorder, or borderline personality disorder.

PATH funding is distributed to each of our seven regional mental health centers, which are responsible for delivering the needed and appropriate services. State general funds are used by each DHW Region to supplement PATH Grant allocations; however, PATH grant monies are the primary source of funding for services to persons that with serious mental illness who are homeless.

PATH funds are used to provide services, basic housing essentials and emergency housing for adults with a serious mental illness and are homeless or at risk of becoming homeless. The availability of these funds prevents the vulnerable population of severely mentally ill adults from becoming homeless by enabling them to receive services to stabilize their lives, find and maintain housing, and access basic services in the community.

Due to annual variations in the grant award, services will be provided on an as needed basis with the exception of contracted funds within each region and those funds targeted for specific projects. This option will allow the regions flexibility in providing services to the homeless population.

The following services are available through the PATH program to be included within the scope of the regional plans: outreach; screening and diagnostic treatment; habilitation and rehabilitation; vocational rehabilitation; community mental health; alcohol or drug treatment;

staff training; case management; supportive and supervisory services in residential settings; referrals for primary health, job training, education; housing services; contracts with nonprofit consumer agencies for supportive services which include case management, contracted outreach and drop-in center services; and contracts with housing providers to enable greater housing availability.

Shelter Plus Care housing is also available in each of the regions of the state and assists in providing housing to those with a mental illness who are homeless. The Shelter Plus Care program is administered by Idaho Housing and Finance Association (IHFA). The FACS Division is in the process of completing a statewide agreement with IHFA which will replace the local regional agreements. This agreement is for the provision of mental health services match for the Shelter Plus Care federal grant.

2. DESCRIPTION OF THE MANNER IN WHICH MENTAL HEALTH SERVICES WILL BE PROVIDED TO INDIVIDUALS RESIDING IN RURAL AREAS.

This portion of narrative will consist of the following sections:

- Definition of "rural."
- Population density.
- Implications of "rural" in mental health service delivery.
- How are mental health services delivered in rural areas of Idaho?

a. Definition of "Rural"

For the purposes of this document, we will conform to the classification system that is followed by the Federal Census Bureau. Under their classification, an urban county is defined as a county having a population center of greater than 20,000. A rural county is defined as a county having no population center of 20,000 or more, yet an average of six or more persons per square mile. A frontier county is defined as a county that averages less than six persons per square mile. Only 8 of Idaho's 44 counties are classified as "urban."

b. Population Density

Of the fifty states, Idaho ranks 13th in area size with 83,557 square miles and ranks 42nd in population. According to the Census Bureau, 66.4% of Idaho's population lived in urban areas, and 33.6% lived in rural areas in 2000.

In accordance with the 2000 census, there was an average of 15.6 persons per square mile in the state compared to the national average of 79.6 persons. Idaho counties with the largest population in 2000 were Ada (300,904), Canyon (116,675), Kootenai (108,685), Bonneville (82,522), Bannock (75,565) and Twin Falls (64,284). There are 19 counties under the population of 10,000. The least populated counties, under 5,000 population, include Camas, Clark, Butte, Adams, Lewis, Lincoln, Oneida, and Custer. There are 8 counties classified as "urban," 20 as "rural" and 16 as "frontier."

c. Implications of "Rural" In Mental Health Service Delivery

A review of the literature relating to human services delivery in rural areas in the USA identifies

a range of social, psychological and economic factors that must be considered in delivering services in rural areas. Among these factors are:

(1) Low population densities make it difficult to provide some services (for example, inpatient treatment) which require a "critical mass" of consumers to be economically and programmatically viable.

(2) There can be difficulties associated with the availability of professionally trained staff in rural areas. In addition, it is often difficult to attract and retain qualified staff to move to rural areas to work.

(3) The incidence of poverty is likely to be higher in rural areas.

(4) In rural areas, long distances and lack of transportation options can be barriers to service access.

(5) Social and geographical isolation can produce significant psychological difficulties for the individual and the family.

d. How are Services Delivered in Rural Areas of Idaho?

It is clear from the statistics stated above that Idaho is predominantly a rural state. Staff in our state-provided community mental health system have developed extensive skills and knowledge about how to effectively and efficiently deliver services to isolated rural communities and individuals.

Below are listed some of the ways in which the public adult mental health system in Idaho has attempted to address and reduce some of the inherent problems of rural service delivery.

(1) The state has made and continues to make significant investments in technology, including personal computers and computer networks, laptop computers, cellular phones, electronic mail and fax machines. Telephone conference calls, with the ability to bring together 10 or 12 individuals from all over the state, are used extensively. In the area of electronic mail, we have a daily system of notification regarding admissions, discharges and problem cases at the state hospitals. During FY 2004, the innovation of tele-mental health will continue to be explored and evaluated as a resource for delivery of services to rural areas.

(2) Significant resources are committed to transportation costs (especially the purchase and lease of vehicles) to enable workers in the field to staff satellite offices, make home visits and respond to community crises.

(3) Evolving methods of treatment (e.g., Assertive Community Treatment, psychiatric rehabilitation, and mobile crisis teams) in the state represent a movement away from office or clinic-based service to services delivered in the client's community setting. This is an approach that is much more responsive to the needs of persons residing in rural areas.

(4) The state's support for consumer empowerment and self-help can also be seen as a way of "extending" the limited resources of our rural state to better serve the seriously mentally ill by developing the "natural support" system. Other methods of "service extension" that are occurring include the development of networks of private providers under the Medicaid Rehabilitation Option.

(5) As described previously, adult mental health services are delivered through seven regional community mental health centers. In addition to the location of each CMHC in the seven population centers, each region has field offices that are regularly staffed and which provide access to services for those living in the more remote areas of the state. Details are as follows:

STATEWIDE MENTAL HEALTH CENTERS – JULY 2002

REGION	REGIONAL CMHC	FIELD OFFICES
I	Coeur d' Alene	St. Marie's, Bonners Ferry, Sandpoint, Kellogg
II	Lewiston	Grangeville, Moscow, Orofino
III	Caldwell	Payette
IV	Boise	Mountain Home, McCall,
V	Twin Falls	Rupert, Bellevue, Jerome
VI	Pocatello	Blackfoot, Soda Springs, Malad, Preston, Montpelier
VII	Idaho Falls	

Please see Appendix B for a map of Idaho showing the regional CMHC's and their field offices.

B. GOALS AND OBJECTIVES

GOAL 4: **TO IMPROVE THE ACCESS, QUALITY AND APPROPRIATENESS OF SERVICES PROVIDED TO (A) PERSONS IN IDAHO WHO ARE MENTALLY ILL AND HOMELESS (OR AT RISK OF BECOMING HOMELESS) AND (B) PERSONS LIVING IN RURAL AND FRONTIER AREAS OF THE STATE**

Objective 4.1 A minimum of 1,153 homeless individuals will be served through Federal PATH grant funds and other sources.

Population:	Adults in Idaho who are mentally ill and homeless (or at risk of becoming homeless)
Criterion:	Targeted services to rural and Homeless Populations
Brief Name:	Number of homeless mentally ill receiving services
Indicators:	The number of homeless mentally ill receiving services

Measure:	Number of homeless mentally ill served in FY04
Numerator	
Denominator	
Sources of Information:	DHW databases (DAR, IMHP, CAMIS, VBROD and ABCD)
Special Issues:	It is anticipated the number served will decrease during FY 04 as there will be no new funds available to meet the demands of inflation and increasing expenditures.
Significance:	It is important to demonstrate continued outreach to this vulnerable population, and to account for the expenditure of Federal PATH grant funds. This objective supports the State Planning Council's priorities to develop community supports and resources for housing and to provide equitable access to care and an array of services.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Number of homeless mentally ill receiving services				
Value	1,188	1,252	1,153	
If rate: Numerator: Denominator:				

Objective 4.2 **Each regional CMHC will conduct at least one mental illness awareness training with local providers of homeless services by the end of FY2004.**

Population:	Providers of services to adults in Idaho who are mentally ill and homeless (or at risk of becoming homeless)
Criterion:	Targeted services to rural and homeless populations
Brief Name:	Regional training for providers of homeless mentally ill providers
Indicators:	Number of regional trainings for providers completed
Measure:	Number of regional trainings of providers completed by the end of FY04
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	This objective supports the Planning Council's objective on continuum of care and community supports.
Significance:	Training providers will improve the quality and appropriateness of the services being provided to the homeless mentally ill population in Idaho.

	FY 2002 Actual	FY 2003 Projection	FY 2004 Objective	% Attainment
Performance Indicator: 2. Regional training for providers of homeless mentally ill				
Value	10	7	7	

Objective 4.3 **Provide increased access to mental health services by developing strategies for recruiting and retaining psychiatric service providers and expand the use of emerging technologies such as telehealth services in the rural and frontier counties during FY04.**

Population:	Consumers and public mental health providers in rural areas
Criterion:	Targeted services to rural & homeless populations
Brief Name:	Access to service providers
Indicators:	
Measure:	
Numerator	
Denominator	
Sources of Information:	Regional report
Special Issues:	Much of Idaho's populations reside in rural areas. Providing accessible services to rural and frontier populations continues to be a challenge and priority during this time of limited resources.
Significance:	This objective corresponds to the State Planning Council's priorities of developing a continuum of care and providing equitable access to care.

Objective 4.4 **The Adult Mental Health Program will partner with Idaho Housing and Finance Association in renewing Idaho's Shelter Plus Care Program and will conduct training on Shelter Plus Care to maximize usage and access to housing for homeless mentally ill persons during FY 04.**

Population:	Adults in Idaho who are mentally ill and homeless
Criterion:	Targeted services to rural and homeless populations
Brief Name:	Shelter Plus Care
Indicators:	Continued statewide participation in the Shelter Plus Care Program
Measure:	Training conducted
Numerator	
Denominator	

Sources of Information:	Self report
Special Issues:	The Shelter Plus Care program presents significant opportunities to provide permanent housing for homeless mentally ill persons who would otherwise not have access to housing.
Significance:	This objective supports the Planning Council's priorities to develop community supports and resources for housing.

CRITERION 5

MANAGEMENT SYSTEMS: The plan contains a description of the financial resources, staffing and training necessary to implement the plan, including programs to train individuals as providers of mental health services, with emphasis on training of providers of emergency health services regarding mental health. Also, the plan describes the manner in which the state intends to expend the grant for the fiscal year involved to carry out the provisions of the plan.

A. NARRATIVE

1. DESCRIPTION OF THE FINANCIAL RESOURCES AND STAFFING NECESSARY TO IMPLEMENT THE REQUIREMENTS OF THE PLAN

a. Financial Resources

Please refer to the Maintenance of Effort Report on page 16 of this plan, which describes the total financial resources projected to be available for Idaho's community mental health services in FY04. The major categories of revenue are: State General Funds, Federal Funds, Mental Health Receipts and Other Sources.

b. Staff Resources

Due to a 3.5% budgetary holdback during FY03, 11 full time positions were eliminated in the DHW Adult Mental Health program. Management Services reports the following distribution of full time equivalent (FTE) staff as of 7/1/2003. In addition, the following chart identifies the regional distribution of clinical professional staff and physicians.

STATEWIDE DISTRIBUTION OF STAFF as of 7/01/2003

Region	Statewide Distribution of Clinical Professional Staff**	Statewide Distribution of MD's/Psychiatrists^	Total # of Established FTE's
I	23.8	2	**29.58**
II	19.4	1 Region 3 SHN	**22.10**
III	25	.7	**28.50**
IV	29	6	**37.00**

V	21	3 (includes 1 PA)	**27.78**
VI	26	1 Region 7 SHS	**31.76**
VII	24	1	**29.90**
Division			**4.00**
Total	168.2	24.7	**210.62**

****** Includes both clinical professional staff and clinical supervisors.

^ Includes both full and part-time contractual MD's/psychiatrists and state hospital staff

2. DESCRIPTION OF THE MANNER IN WHICH THE STATE INTENDS TO EXPEND THE GRANT FOR FY2004 TO CARRY OUT THE PROVISIONS OF THE PLAN REQUIRED IN CRITERIA 1 THROUGH 5.

MENTAL HEALTH BLOCK GRANT
Phase 03, 10/1/02 – 9/30/04

	Federal Budget	SFY 03 Expenditures	Total Remaining
Adult Services	$ 923,947	$ 722,494	$ 201,453
Consumer/Family Empowerment	$ 132,000	$ 86,066	$ 45,934
State Planning Council	$ 20,000	$ -	$ 20,000
Other Cons/Family Empowerment	$ 10,000	$ -	$ 10,000
Regional Budgets to Support Personnel	$ 291,315	-	$ 291,315
Training	$ 12,568	-	$ 12,268
Total Adult Services	$ 1,389,830	$ 808,560	$ 581,270
Children's Services/ Jeff D	$ 111,667	-	$ 111,667
Regional/Local Councils	$ 55,000	-	$ 55,000
Respite Care	$ 55,000	$ -	$ 55,000
Family Support/Advocacy Contract	$ 100,000	-	$ 100,000
Total Children Services	$ 321,667	-	$ 321,667
Administration	$ 90,079	$ 38,026	$ 52,053
TOTALS	$ 1,801,576	$846,586	$954,990

Proposed Phase 04 Grant Award

	Federal Budget
ADULT	
Adult Services	$ 923,947
Consumer/Family Empowerment	$ 132,000
State Planning Council	$ 20,000
Other Cons/Family Empowerment	$ 10,000
Regional Personnel Support	$ 291,315
Training	$ 12,568
Total Adult Services	$ **1,389,830**

CHILDREN	
Children's Services/Jeff D	$ 111,667
Respite Care	$ 55,000
Family Support/Advocacy Contract	$ 155,000
Total Children Services	$ **321,667**
Administration	**$90,079**
TOTALS	**$ 1,801,576**

Under the State Planning Council on Mental Health's leadership we are attempting to improve the tracking of expenditures related to the Federal Community Mental Health Block Grant. Since FY 2000 we have directly assigned increases in the Block Grant allocation to specific activities.

The following innovative projects will be specifically funded with Federal Community Mental Health Block Grant (CMHBG) funds in FY2004:

- Consumer and family member empowerment initiatives, including funding for the Office of Consumer Affairs and Technical Assistance, the Idaho Chapter of the National Alliance for the Mentally Ill (NAMI-Idaho), and a statewide consumer conference **(Total $142,000)**

- **$291,315** will be distributed to the seven regional CMHC programs to support their personnel budgets for clinical (direct service) positions.

- **$20,000** will be used to support the meetings and activities of the Idaho State Planning Council on Mental Health and the Regional Mental Health Advisory Boards.

- **$12,568** will be used to support training to enhance best practice standards and competencies in the Adult Mental Health Program.

The remaining Federal CMHBG funds are placed in DHW's Mental Health Cost Pool and allocated to various community mental health program categories by the use of a Random Moment Time Study. It is expressly understood, as required by Public Law 102-321, that no Federal CMHBG funds are to be used for inpatient services.

3. DESCRIPTION OF STAFFING AND TRAINING FOR MENTAL HEALTH PROVIDERS NECESSARY TO IMPLEMENT THE PLAN INCLUDING TRAINING OF PROVIDERS OF EMERGENCY HEALTH SERVICES REGARDING MENTAL HEALTH

The FACS Adult Mental Health Program will continue in FY2004 to assume primary responsibility for identifying the statewide training needs of the public mental health service system. As the Department of Health and Welfare continues its efforts with consolidation and

realignment it becomes increasingly important for the Division of Family and Community Services to focus on greater statewide consistency and the identification of program standards and competencies. A uniform and comprehensive approach to training will allow for a more efficient and effective use of limited resources. Ongoing training needs related to emergency medical services providers and law enforcement will continue to be identified in conjunction with the statewide mental health service providers training needs.

In FY2001, outreach was made to the Bureau of Emergency Medical Services (Division of Health) to begin planning for the training of providers of emergency medical services regarding mental health. A training session was held at a regional EMS provider's conference in Coeur d'Alene, Idaho in May 2001. In 2002 a series of Critical Incident Response trainings was provided. The Adult Mental Health program sponsored a Risk Assessment for Violence training by Phillip Resnick, M.D. in March, 2003. Targeted attendees included CMHC staff, private sector providers and law enforcement. The regional CMHC's provide ongoing training opportunities to their local law enforcement agencies on a regular basis. Training topics include risk assessment, mental hold protocols, available services, stigma and mental illness awareness education.

The Department of Health and Welfare and other agencies participated with the Idaho Bureau of Disaster Services in the development of the revised Idaho Emergency Operations Plan. The plan was revised to align Idaho's plan with the Federal Response Plan. The Division of Family and Community Services is identified as the lead agency for the delivery of mental health care during a disaster emergency. The plan calls for FACS to assist in assessing mental health needs; provide disaster emergency mental health training materials for disaster emergency workers; provide liaison with assessment, training, and program development activities by state and local officials and to administer the Emergency Crisis Counseling Program for the Bureau of Disaster Services. FACS staff will provide "first response" to a disaster in their local areas. The Division's Disaster Crisis Counselor Coordinator is in charge of the crisis counseling program and will work closely with the Bureau of Disaster Services to provide crisis counseling during a presidential declared disaster. The Bureau of Disaster Services is the Governor's appointed representative for disaster response. The Division of FACS and Bureau of Disaster Services will continue joint coordination meetings.

B. GOALS AND OBJECTIVES

GOAL 5: **THE STATE WILL CONTINUE TO USE THE FEDERAL MENTAL HEALTH BLOCK GRANT AS AN OPPORTUNITY TO DEVELOP AND FUND INNOVATIVE PROJECTS, AS WELL AS PROVIDING ADEQUATE FUNDS FROM OTHER NON-FEDERAL SOURCES TO PROVIDE ACCESSIBLE, HIGH QUALITY AND APPROPRIATE MENTAL HEALTH SERVICES TO THE TARGET POPULATION, AND WILL PROVIDE TRAINING TO MENTAL HEALTH SERVICE PROVIDERS AND OTHER SPECIALIZED GROUPS.**

Objective 5.1 A statewide consumer conference will by held by the end of FY04.

Population:	Consumers of mental health services
Criterion:	Management systems
Brief Name:	Consumer conference
Indicators:	Consumer conference conducted
Measure:	
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	This supports the Planning Council's priority to support consumer involvement.
Significance:	Idaho remains committed to consumer empowerment and recovery and will commit funding to support a statewide consumer conference.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 1. Consumer Conference				
Value	N/A	N/A	1 statewide	

Objective 5.2 The FACS Division will provide statewide training on Assertive Community Treatment by the end of FY04.

Population:	Providers of public mental health services and emergency medical service providers in Idaho
Criterion:	Management systems
Brief Name:	Training for mental health service providers
Indicators:	Training provided
Measure:	Number of training opportunities completed
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	Continued opportunities for training related to ACT and crisis response have been identified as training priorities by the CMHC programs.
Significance:	This objective supports the Planning Council's priorities on quality and continuum of care.

Objective 5.3 **The FACS Division will conduct an evaluation of the core services for the Adult Mental Health program in order to develop standards and competencies for best practice in the public mental health system during FY04.**

Population:	Providers of public mental health services
Criterion:	Management systems
Brief Name:	Evaluate Core Services
Indicators:	Core services evaluated
Measure:	Standards and competencies developed
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	A primary goal for the FACS Division is to achieve greater statewide consistency and improve clinical competencies.
Significance:	This objective also supports the Planning Council's priorities related to quality and continuum of care.

Objective 5.4 **The Adult Mental Health Program will provide no less than one training opportunity for CMHC staff related to substance abuse treatment during FY2004.**

Population:	Providers of public mental health services in Idaho
Criterion:	Management systems
Brief Name:	Training on substance abuse treatment
Indicators:	Number of training opportunities provided.
Measure:	Number of training opportunities completed
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	A continued opportunity for training related substance abuse treatment is especially important. It is estimated that 50% to 70 % of persons with a serious mental illness also have a substance abuse problem.
Significance:	This objective supports the Planning Council's priorities on quality and continuum of care.

	FY 2002 Actual	**FY 2003 Projection**	**FY 2004 Objective**	**% Attainment**
Performance Indicator: 4. Training on substance abuse treatment				

Value: Number of training opportunities completed	1	1	1	
If rate: **Numerator:** **Denominator:**				

Objective5.5 The Adult Mental Health Program will develop and adopt a standardized Designated Examiner training program during FY04.

Population:	Providers of public mental health services in Idaho
Criterion:	Management systems
Brief Name:	Designated Examiner training
Indicators:	Training program developed
Measure:	Training program developed
Numerator	
Denominator	
Sources of Information:	Self report, Management Services
Special Issues:	A primary goal of the FACS Division is to achieve greater statewide consistency and improve clinical competencies.
Significance:	This objective supports the Planning Council's priorities on quality.

Objective 5.6 The Adult and Children's Mental Health Programs will develop and provide joint training on the provision of mental health services to children with SED and adults with SPMI for Healthy Connections primary care physicians during FY 04.

Population:	Providers of public mental health services and Healthy Connects primary Care Physicians in Idaho
Criterion:	Management systems
Brief Name:	Training for primary care physicians
Indicators:	Training developed and provided
Measure:	Number of training opportunities completed
Numerator	
Denominator	
Sources of Information:	Self report
Special Issues:	
Significance:	This objective corresponds with the New Freedom Commission Recommendation 1.2 which recommends addressing mental health with the same urgency as physical health as well as the State Planning Council's Adult Mental Health priorities related to continuum of care.

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